COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

CULTURAL COMPETENCE PLAN 2010

COUNTY OF SAN DIEGO MENTAL HEALTH SERVICES
SEPTEMBER 2010

INTRODUCTION

The County of San Diego has long had a commitment to cultural competence. Sharing a border with Mexico, San Diego has one of the highest rates of immigration of all of California's counties. A Brookings Institution report says that more than 22% of San Diego's population was born in another country and 42% of children have one or more foreign born parent.[1] In addition to ongoing immigration from Mexico, Central America, and South America, recent immigrants have included people from Iraq, East Africa and Burma.

The need to provide physical and mental health services to persons from many, diverse cultures has been acknowledged throughout all parts of the County's Health and Human Services Agency, whether it be through Public Health, Behavioral Health, Aging and Independence Services, County Medical Services, etc. for persons receiving Medi-Cal and low income residents. The Health and Human Services Agency for San Diego has begun a ten year effort called the "Building Better Health Program" to align County services to promote both physical and mental health in collaboration with community partners and businesses. The goals are to build a better system, support healthy choices, pursue policy changes for a healthy environment, and to improve the culture from within (for County employees.)

The County of San Diego provides mental health services to over 60,000 children, youth, transitional age youth, adults, and older adults each year. The services are largely contracted out, with very few County programs. The SDCMHS and its contractors provide services through approximately 200 programs, 350 school based mental health sites, and over 700 Fee for Service practitioners under contract to the SDCMHS's Administrative Services Organization, UBH - OptumHealth.

San Diego County Behavioral Health Services (composed of County Mental Health Services and Alcohol and Drug Services) incorporated the recognition and value of racial, ethnic, and cultural diversity within its system, and including these values its first Cultural Competence Plan in 1997. San Diego County Mental Health Services (SDCMHS) sees the creation of a truly culturally competent system as a developmental process. Some of the needed steps require additional resources, whether it be funding for culturally specific programs or the growing of bi-lingual staff at all levels, and some require a shift and increase in administrative focus. The groundwork has been laid through the creation of policies and procedures and requirements for contractors and, we have been building upon this framework ever since.

To determine whether all population groups in the County were getting needed assistance with mental health issues, the SDCMHS conducted its Gap Analysis, looking at the differences in services received by age group and race/ethnicity. In 2009, the County measured its service provision by age and culture to understand whether noted disparities were being addressed and created "Progress Toward Reducing Disparities: A Report for San Diego County Mental Health Services: Five Year Comparison FY 2001-2 to FY 2006-2007". Through MHSA funding, adult and children's mental health services have been expanded to start to erase the disparities noted in these reports. But much is still left to do.

The Cultural Competence Plan is a report about where the SDCMHS is now and where we plan to go. It includes information on the eight criteria set by the State as indicators of cultural competence:

1. Commitment to Cultural Competence
2. Updated Assessment of Service Needs
3. Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
4. Client/Family member/Community Committee: Integration of the Committee within the County Mental Health System
5. Culturally Competent Training Activities
6. County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
7. Language Capacity
8. Adaptation of Services

1. "The State of Metropolitan America", Brookings Institution as cited by Katie Orr, KPBS, May 10, 2010.

Note: Copies of the Gap Analysis and the Progress Toward Addressing Disparities Report can be found in the Appendix, Criterion 2, pp. 2.III.B.1-81.

SDCMHS METHODOLOGY IN EVALUATING ITS SYSTEM

In planning for services the County of San Diego Mental Health Services considers the combined needs of the Medi-Cal and <200% poverty populations, since approximately 45% of clients are in the latter category. To understand the needs of the whole County mental health population for MHSA planning, the SDCMHS and its USCD Research Centers conducted the Gap Analysis and analyzed its service disparities in a report called " Progress Towards Reducing Disparities: A Report for San Diego County Mental Health , Five Year Comparison FY 2001-2001 to FY 2006-07". These reports provide more definitive information by age and race/ethnicity, as well as service usage and diagnosis, which we have used to supplement the State required information.

Although the SDCMHS functions as a unified whole, the focus of the services for adults/older adults and children/youth differs slightly, as is age appropriate. The adult system focuses on psycho-social recovery and children's system focuses on family centered treatment and resiliency. For the purposes of this report, much of the information on programs, initiatives, and future activities are divided into sections dealing with the system as a whole, adult/older adult services, and services for children and youth.

DIRECTOR'S MESSAGE ON CULTURAL COMPETENCE PLAN

San Diego County's Cultural Competence Plan represents the goals, tremendous effort and execution, and organizational discipline of County employees, providers, system partners, community representatives, family members, and most importantly, clients.

There are individuals that deserve special recognition. Piedad Garcia is recognized for her leadership in building on a legacy of the County's commitment to cultural competency. We are grateful for the work of Candace Milow, Director of Quality Improvement, Kathy Anderson, Performance Outcomes Manager, and Kristin Akerele, Alfie Gonzaga, and Edith Mohler, Analysts, who collected, analyzed, and organized the numerous data sources and relevant activities reports contained in this plan.

Finally, on behalf of the County of San Diego, I express our gratitude and appreciation to the Cultural Competence Resource Team (CCRT) for their enduring commitment and vigilance to ensure that all of our programs and services strive to meet the cultural and linguistic needs of our community.

Sincerely

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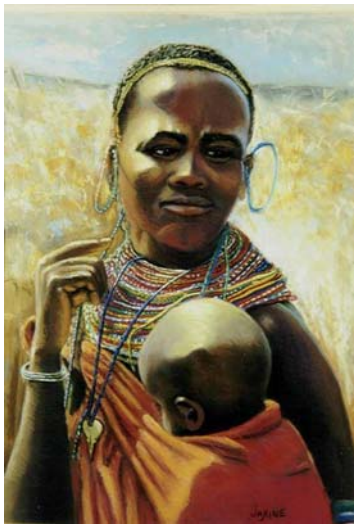
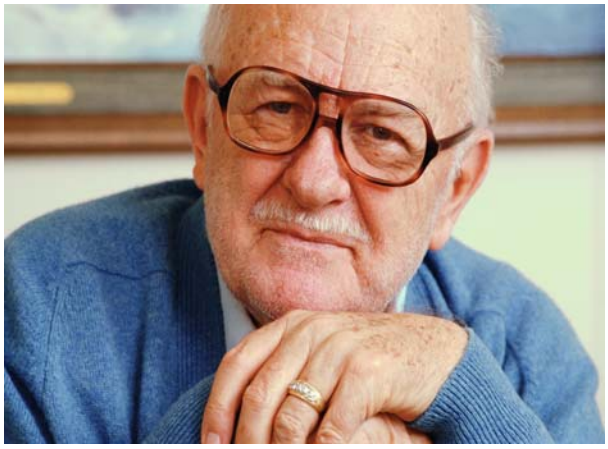
CRITERION 1

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

COMMITMENT TO CULTURAL COMPETENCE





CRITERION 1 – COMMITMENT TO CULTURAL COMPETENCE

COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR:

A. Policies, procedures, or practices that reflect steps taken to dully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

San Diego County Mental Health Services (SDCMHS) and the County of San Diego have in place the following policies, procedures, and practices recognizing and valuing cultural diversity:

County of San Diego Department of Human Resources Policies

San Diego County's Department of Human Resources (DHR) has policies in place that reflect recognition of racial, ethnic, and cultural diversity in areas of training and recruitment. These include:

- 1002 – Training and Development Program – "It is the policy of DHR to assist all employees in professional development through consultation, coaching, education and training." One such training opportunity that addresses cultural competency is Embracing Diversity and Encouraging Respect, which the County strongly encourages each employee to take.
- 109 – Equal Employment Opportunity – "It is the County's policy to provide the conditions which promote equal employment opportunity for all persons regardless of race, color, ancestry, national origin, religion, sex, marital status, age, sexual orientation, political affiliation, or disability."
- 902 – Employee Organizations – "It is County policy to maintain positive and productive relationships with employee organizations to assure that all County practices are free from discrimination based on employee organization membership or participation by County employees."

SDCMHS Policies and Procedures:

SDCMHS has had a number of policies and procedures in place for almost ten years to ensure culturally appropriate services are available. These include:

- 01-01-203 – Culturally and Linguistically Competent Services: Assuring Availability. This policy and procedure assures improvements in the availability of culturally and linguistically competent services for individuals accessing County Mental Health Services.
- 01-01-207 – Cultural Competence Resource Team. This policy and procedure describes the process for San Diego County Mental Health Services' Cultural Competence Committee to advise the Deputy Directors of Adult/Older Adult and Children's Mental Health Services on issues of cultural competency.
- 01-02-202 – Provision of Culturally and Linguistically Appropriate Services. The purpose of this policy and procedure is to ensure that all individuals requesting services at Specialty Mental Health Plan programs have been evaluated for needing culturally/ linguistically specialized services and linked with services or referred appropriately.
- 01-02-203 – Interpreter Services: Access and Authorization. This policy and procedure establishes a process to provide free interpreter services for mental health clients with Limited English Proficiency, which includes provider service authorization and the requirements for processing of payments for interpreter services.
- 01-04-210 – Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services. Policy and procedure 01-04-210

ensures that all threshold language-speaking clients and clients needing information in alternate formats receive information in writing or in an appropriate manner to their special need to assist them in accessing Specialty Mental Health Services.

- 01-06-207 – Grievances, Appeals, Expedited Appeals and State Fair Hearings: Monitoring the Beneficiary and Client Problem Resolution Process. The Grievance and Appeal process is set up to ensure that client rights are maintained to their fullest extent, including providing language translation and interpretation services, as needed.

SDCMHS Principles Which Support Cultural Competence:

The County of San Diego has two "systems of care" -- one for Adult/Older Adult Mental Health and one for Children's Mental Health which work together to create the Mental Health System. Additionally, the Community Services and Support (CSS) component of the Mental Health Services Act and the Comprehensive Continuous System of Care for co-occurring substance abuse have guiding principles addressing cultural competence which further embed this value in SDCMHS.

Adult and Older Adult System of Care (AOAMHS) Principles**:**
The AOAMHS System of Care is based on Biopsychosocial and Rehabilitation (BPSR) principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. Biopsychosocial rehabilitation and recovery services are comprehensive, culturally competent, and age appropriate and tailored to individual client's needs and choices within their cultural context. The Adult System of Care Guiding Principles are in the Appendix, Criterion 1, p. 1.I.A.1.

Children's System of Care (CSOC) Guiding Principles
The CSOC Council's Vision is that San Diego children and youth are healthy, safe, and successful in school, and law abiding, while living in a home and community that supports strong family connections. There are eight Guiding Principles of the CSOC including that services are culturally, linguistically, and developmentally appropriate. The CSOC Guiding Principles are in the Appendix, Criterion 1, p.1.I.A.2.

Community Services and Supports (CSS) Vision Statement and Guiding Principles
In addition to the Systems of Care described above, SDCMHS has implemented MHSA Community Services and Supports (CSS). This includes:

- Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns and motivations.
- Development and expansion of practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures.
- The Guiding Principles of CSS include cultural competency items such as:
  Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services.
- Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation, and religious/spiritual beliefs.

Comprehensive Continuous Integrated System of Care (CCISC) – Co-Occurring Disorders
The CCISC initiative utilizes eight practice principles that directly impact the way services are planned and provided for the special cultural population of dually diagnosed (with mental health and substance abuse disorders) individuals in the mental health system. CCISC Training is available to County and contract mental health staff to help ensure programs become "dually diagnosed capable or enhanced" and work collaboratively across systems to improve services. In addition, the San Diego County Adult and Older Adult Mental Health Services (AOAMHS), Children's Mental Health Services (CMHS), and Alcohol and Drug Services (ADS), with support of both the Mental Health and Alcohol and Drug

Advisory Boards have agreed to adopt the CCISC model for designing system changes to improve outcomes for persons with co-occurring issues, within the context of existing resources, via a Consensus Document.

SDCMHS Organizational Provider Operations Handbook: Cultural Competence

San Diego County Mental Health System maintains an Organizational Provider Operations Handbook which is an addendum to all provider contracts. The handbook is updated at a minimum annually and serves as a way for the SDCMHS to keep its contractors up to date on new or changing requirements for the provision of services. The Handbook contains a "Cultural Competence" section which includes Culturally Competent Clinical Practice Standards to be followed, such as:

- Staffing at all levels - clinical, clerical, and administrative shall be representative of the community served.
- Cultural and ethnicity requirements include consumers given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers.
- Services should be provided in the client's preferred language. Providers are required to inform individuals with Limited English Proficiency, in a language they understand that they have a right to free language assistance services. The offer of interpreter services and the client's response must be documented.
- Facility requirements include having providers ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations in order to present a welcoming appearance to unique communities.
- Additional Program Standards include a recommendation to develop a program-specific cultural competence plan, the need for development of a documented process to evaluate the linguistic competence of staff, and a requirement to conduct an annual client focus group with monolingual and multilingual clients to assess program and staff cultural competence and community needs.
- Monitoring Cultural Competence addresses how the SDCMHS Quality Improvement (QI) unit will monitor presence of multi-cultural and linguistic staff and language appropriate service provision through Medical Record Reviews, Monthly Status Reports, Site Reviews, etc.
- Evaluating Cultural Competence section includes recommendations on using the Culturally Competent Program Annual Self-Evaluation (CC-PAS) which is provided in the Handbook to evaluate the program's cultural competence.

The complete Cultural Competence section of the Organizational Provider Operations Handbook is included in the Appendix, Criterion 1, pp.1.I.A.3-9.

Clinical Records Manual

The Clinical Records Manual includes a Mental Health Assessment which requires information on the client's ethnicity, language, culture specific symptomatology/explanations for behavior, support systems, alternative health practices, cultural issues, and any family history of immigration and acculturation issues.

Next Steps Toward Increasing the Emphasis on Cultural Competence

The SDCMHS has been in the process of converting its system and all providers to the Electronic Health Record, which has resulted in significant staff training time for contractor and County staff. This conversion is expected to be completed in FY 10-11, freeing up contractors to focus additional time on building cultural competence. In the FY 11-12, SDCMHS is planning to make mandatory the need for all new providers, as well as all programs re-procuring contracts, to have a Program-specific Cultural Competence Plan. Using the Recovery Self-Assessment tool for clinicians, SDCMHS has begun in FY 10-11 to get staff feedback on their assessment of cultural competence of their programs; Administration is considering making annual completion of the RSA a contract requirement. In FY 11-12, SDCMHS also plans to make mandatory the now recommended use of the CC-PAS on an annual basis, in order to continue to reinforce awareness of cultural competence as a program goal. SDCMHS

QI has begun to collect program specific data on the race/ethnicity of clients served and is planning to compare it to targeted populations.

The county shall have the following available on site during the compliance review:

B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. *Mission Statement;*
2. *Statement of Philosophy;*
3. *Strategic Plans;*
4. *Policy and Procedures Manual;*
5. *Human Resource Training and Recruitment Policies;*
6. *Contract Requirements*
7. *Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence)*

SDCMHS shall have items 1-7 available on-site during the compliance review.

COMMITMENT TO CULTURAL COMPETENCE

II. County recognition, value, and inclusion of racial, ethnic, cultural and linguistic diversity within the system

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR.

The county shall include the following in the CCPR:

A. A description, not to exceed two pages, of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

The SDCMHS has traditionally solicited stakeholder input on mental health programming through a variety of committees, councils, workgroups, etc, ranging from client representatives participating in the SDCMHS Administration Core Planning Group to large stakeholder meetings. When MHSA funding became available, an even more extensive effort was made to include participants from identified racial, ethnic, cultural, and linguistic communities with mental health disparities. Recognizing and valuing the diversity of County residents, a range of vehicles was used to ensure a wide scope of opportunities to provide input and ideas on needed improvements to mental health services. Community forums, regional meetings, focus groups, surveys, and the formation of age-focused ongoing Advisory Councils contributed to decisions to create programs which operationalize community outreach and engagement and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities:

Adult/Older Adult Mental Health Programs:

The following programs focus on Adults and Older Adults demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities:

- The Breaking Down Barriers (BDB) program provides outreach, engagement, and education to persons with a severe mental illness who are members of unserved and underserved populations from culturally diverse populations. These target populations include members of the Latino, Native American (Rural and Urban), Lesbian-Gay-Bisexual-Transgender-Questioning (LGBTQ), and African American communities. BDB works to create effective collaborations with other agencies, community groups, client and family member organizations and other stakeholders in selected pilot communities throughout San Diego County.
- The Fotonovela project that will launch in FY10-11 will develop, publish and distribute a Fotonovela that will reach out to the Latino community on mental health issues, including information on how and where to access mental health services. As part of a "stigma busting" effort, the aim of the project is to increase community awareness. The project has been spearheaded by its steering committee which consists of County adult/older adult mental health staff, program managers from service providers, mental health consumers, and contractor staff.
- Elder Multicultural Access and Support Services (EMASS) program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County. EMASS is an age and culturally/linguistically appropriate, peer-based, outreach and engagement model to support prevention activities and increased access to care. It utilizes "Promotoras" or Community Health Workers (CHW) as peer liaisons between their communities and health, human services, and social organizations to bring information to their communities. The CHWs' function as advocates, educators, mentors, outreach workers, role models, cultural brokers, and translators.
- Peer Operated Clubhouses provide services that assist members to increase their social rehabilitation skills, reduce social isolation, increase independent functioning, and increase and improve education and employment. The Friendship Clubhouse serves the Adult and Transitional Age Youth (TAY) African-Americans and Latinos that are unserved. The Eastwind Clubhouse provides culturally competent services to Asian/Pacific Islanders in their preferred languages. Casa del Sol has a special focus on the adult, older adult and TAY Latino populations.
- Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery Centers (WRC) provide outpatient mental health rehabilitation and recovery services, co-occurring substance abuse disorders treatment, case management, and vocational services for seriously mentally ill (SMI) clients (ages 18 and over) including those who may have a co-occurring substance abuse disorder. The Maria Sardiñas BPSR WRC provides services to the underserved Latinos in the County's South Region. The Union of Pan Asian Communities (UPAC) BPSR WRC exclusively serves Asian/Pacific Islanders in their preferred language. The Chaldean-Middle Eastern Social Services Behavioral Health Program serves the County's East Region Middle Eastern refugees.
- Outpatient Services for Deaf and the Hard of Hearing provides specialized, culturally, linguistically and developmentally appropriate outpatient BPSR services for Medi-Cal and un-funded deaf and hard of hearing persons of all ages who are seriously mentally ill, as well as those who may also have co-occurring substance abuse disorder. Providers are American Sign Language (ASL) fluent and members of the Deaf community. Effective July 1, 2010, services have been expanded to provide alcohol and drug counseling with the addition of an experienced and certified Alcohol and Drug counselor who is ASL-fluent.
- Courage to Call – a veteran-staffed 24/7 Helpline provides free confidential information, guidance, and referrals to individuals who have served and their families. The program also provides training to improve cultural awareness and understanding for community organizations and providers serving those with a military or military family background.

Children's Mental Health Programs:

The following programs focus on Children and Adolescents demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities:

- Crossroads Program -- Provides outpatient mental health services to children, youth, and their families in the underserved rural 1000 mile square "backcountry" of East San Diego County.

Clinicians understand the unique needs and differences of the backcountry culture and population. Services are provided where they are most convenient and appropriate which includes schools, homes, church, community meeting centers, or even under the oak trees in an outdoor setting.

- Community Circle Central -- Provides mental health outpatient community and school based services primarily to Latino, Spanish-speaking children, youth, and their families. The Cultural Access Resource Enhancement (CARE) program provides cultural/language specific outpatient mental health services to the target population of underserved Latino and Asian Pacific Islander children and families.
- Nueva Vista Program -- Provides mental health services and alcohol and drug services. It is dual diagnosis capable and culturally sensitive to its service community with over 50% of staff being bilingual (Spanish) and bicultural (Latino).
- Para Las Familias Program -- Provides outpatient family based services to children ages 0-5 and their families. It focuses on delivering services with an emphasis on behavior interventions that meet the unique needs of each family taking into account cultural, linguistic, economic and other factors that impact their lives.
- Palomar Family Counseling -- Provides outpatient mental health services to children ages 0-5 and their families. The program implements Incredible Years and utilizes a "Promotora" component that is bicultural and bilingual and reflects the Latino community served.
- Harmonium Family/Youth Partner Full Services Partnership Program -- Serves children and Transition Age Youth. Because of the higher rates of obesity, diabetes, and hypertension in Hispanic and African American youth, the integration of medical and mental health services is part of the treatment spectrum with a focus on helping clients achieve mental health treatment goals.
- Family and Youth Peer Support Lines -- Provides outreach by phone to promote mental health prevention and early intervention at schools, children and youth centers, community and family centers, and children's and public mental health systems/programs. The Support Lines focus on high-risk, low socio-economic communities with high concentration of ethnic minorities, including underserved Asian and Pacific Islanders, Latinos, and military families.
- The Urban Youth Center of the Indian Health Council -- Serves at risk and high risk Urban American Indian and Alaska Native children and youth ages 10-24 and their families providing screening and assessment and individual counseling by counselors or Spiritual Advisors. The center serves as a central location for local tribal youth.

Adult and Children's Mental Health Educational Forums:

In addition to the programs described above, educational forums or conferences are held each year on selected topics of particular interest to the mental health community. Integration of mental health and physical health services has become a priority in the adult mental health community due to the reports on the 25 year shorter life expectancy of those with mental illness and the need to reach out in different ways to engage ethnic cultures. Over 200 stakeholders attended a full-day conference held on June 22, 2010 to discuss the importance of care integration.

For children and their families, the County sponsored: 33 family-youth forums on "Understanding Effective Services" and "Benefits to Partnering with Public Systems"; some of these forums were conducted in Spanish. There were 11 forums each in North, South, and East regions of the County to reach out to various racial/ethnic groups, with a total of 185 families/youth attending.

B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

Both the Adult/Older Adult System of Care and the Children's System of Care of the County of San Diego County Mental Health Services seek to further client and family engagement and involvement of ethnically and linguistically diverse clients at all levels of the mental health planning process. The following describes these engagement and involvement efforts.

Adult/Older Adult Mental Health Engagement & Involvement Efforts:

- In order to provide feedback and recommendations to the Mental Health Director on the design and implementation of the Adult/Older Adult Mental Health System of Care, the following bodies were established: the Adult Mental Health System of Care Council, the Older Adult Mental Health System of Care Council, the Mental Health Services Housing Council, and the Transition Age Youth (TAY) Workgroup. These groups have a voice in policy development as well. Members are appointed from constituencies including: community organizations, Mental Health Board, Community College District, Transition Age Youth, Older Adults, Primary Health Care, Advocacy, National Alliance for Mental Illness (NAMI), Mental Health Contractors Association, Alcohol and Drug Services, Employment Services, Probation, Sheriff, Local Police Department, Fee For Service mental health practitioners, Cultural Competence Resource Team, Co-Occurring Disorders/CADRE, Mental Health Coalition, Hospital Partners, Underserved Communities, Long Term Care, Service providers for Older Adults, Mental Health Services Housing Council, Veterans Services, Case Management, consumers and family members. Diverse consumer and family cultural representation is also sought.

- Program Advisory Groups (PAGs), composed of at least 51% mental health consumers and/or family members, are a required program component for Outpatient Programs. PAGs, which are ideally facilitated by peers/family members, provide feedback and ideas to mental health programs about improving recovery services. PAG meetings have a format, agenda, and record attendance and minutes. Through Recovery Innovations of California (RICA), PAGs have established implementation guidelines across the Adult Mental Health System of Care in an effort to standardize this important vehicle for soliciting feedback to improve programs.

- The County of San Diego Mental Health Board (MHB), with over 50% client members is developing a statutorily required report to the California Mental Health Planning Council to give the MHB's input on the county's penetration and retention rates across Race/Ethnicity, Age and Gender. Led by a special Study Group, the MHB has completed Phase I of the report on: Race/Ethnicity issues and is working on Phase II: Age and Gender issues. The report will include the MHB's recommendations for addressing disparities based on the evaluation of the data. The MHB continues to work on improving the cultural diversity of its membership to try to more closely reflect the makeup of the mental health community.

- The SDCMHS Quality Review Council involves a culturally diverse and representative group of members including community mental health organizations, clients and family members, service providers, client run services, and educational organizations. The members participate in the review of ongoing program monitoring, program and client outcomes and system problems to help ensure that clients continue to receive high quality, effective services in a recovery oriented system.

- The San Diego County Mental Health Services' (MHS) Spirituality and Recovery Initiative (SRI) began in 2008 to support the State SRI. In June 2009, the County sponsored 16 consumers and family members to the Southern Region Spirituality & Recovery two day conference. Since then, County MHS has convened six bi-monthly workgroups to develop and implement the SRI in San Diego County MHS. Workgroup members include consumers, family members, direct service practitioners, and advocates who attended the 2009 conference. In Spring 2010, a consumer conference hosted by Recovery Innovations of California (RICA) included a spirituality and recovery workshop that was provided by members from multiple faith based denominations. The SRI Workgroup's plan for the next two years include: 1) the development and implementation of in-service educational opportunities with Faith Based Communities (FBC) to discuss mental health issues and how to

integrate spirituality in direct services, as well as to provide information on available resources; and 2) the development and implementation in-service educational opportunities for mental health providers to discuss the integration of spirituality and recovery in the delivery of services in the systems of care. These opportunities are expected to include non-religious spiritual views and beliefs.

Additionally, the SDCMHS, through its children's mental health service system, has been working with the Project to Save Our Children to address disproportionality and disparities in serving youth and families in southeast San Diego. Specifically targeted are the issues of African American youth. The SDCMHS is joining efforts with the faith based community and other stakeholders to help increase access and breakdown the stigma of individuals and families experiencing mental health conditions. This project is still in the early stages of development and will include collaboration with Probation and Child Welfare.

- Through the National Alliance for Mental Illness (NAMI) San Diego, the Family to Family program reaches out to families that support relatives living with mental illness. This 12-week program provides an understanding about mental illnesses as well as a wide array of coping skills. The program is offered in Spanish, Vietnamese, and Arabic. NAMI also provides a 10-week Peer-to-Peer education program that engages people living with mental illnesses and provides them information on the illnesses, its treatment, how to prevent a relapse, and living well. It is offered in English and Spanish.

- Community Based Organizations – San Diego County Mental Health Services has new, significant activities that involve community based organizations. Recently funded by Prevention and Early Intervention, Community Health Promotion Specialists and Aging Specialists bring mental health awareness to the general public and to those populations not normally seen within the County Mental Health System who may be at risk for developing mental illness. Aging Specialists have incorporated "Good Mental Health is Ageless" training in presentations to provided to community groups including the older adult population and Hispanic older adult population. In addition, staff sent mental health information, resources and event notices throughout the Community Action Networks, which are a distribution network of over 850 community organizations, individuals and networks. Staff attend Health Fairs throughout the county to distribute information and talk about mental health to community members. Staff also coordinate special events such as the discussion of the San Diego County Report Card on Children and Families, including mental health and substance abuse data, and the "Es Dificil Ser Mujer" workshop. Coming in FY 2011-12, the SDCMHS, in conjunction the County Purchasing and Contracting and HHSA Contract Support, is planning to conduct another community training for non-traditional CBOs to build the capacity to be a mental health provider.

Children's Mental Health Engagement and Involvement Efforts:

- The central advisory council is the Children's Mental Health Services System of Care Council. The Council provides community oversight on the integrity of all services and advancements of all aspects of the system of care as well as advice and feedback related to the progress and future expansion of the Children's Mental Health Services system of care. The Council meets monthly and has member representation from the:
  - ✓ Mental Health Board
  - ✓ Special and regular education sectors
  - ✓ Family sector representing the Family and Youth Roundtable of San Diego County, family and youth consumers of mental health services
  - ✓ Youth sector representing youth who currently receive, or have received services from Child Welfare Services, and or the Juvenile Justice system
  - ✓ Mental Health Providers
  - ✓ Public sector representing child serving agencies of the Health and Human Services Agency of the County of San Diego
  - ✓ Commission on Children, Youth and Families

- ✓ San Diego Regional Center for the Developmentally Disabled
- ✓ County of San Diego Probation, County of San Diego Juvenile Court, At-Large Constituency, and First 5 Commission

- The Family/Youth Liaison (FYL) program has the primary duty of coordinating and advancing family youth professional partnerships in Children's Mental Health Services (CMHS). The FYL Director works closely with CMHS administrative staff to ensure that family and youth voice and values are incorporated into MHSA services development and implementation plans. The FYL conducted eight focus groups on the development of the County's Prevention and Early Intervention programs, targeting Native American, African American, Hispanic/Latino, Asian/Pacific Islander, Refugee/Immigrant, Lesbian, Gay, Bisexual, Transexual and Questioning (LGBTQ), Youth and family members and underserved populations. During FY 09-10, the FYL hosted a total of 33 family-youth forums including three in Spanish. MHSA Innovations Plan Review forums and Therapeutic Behavioral Services focus groups with youth and families in English and Spanish were also conducted.

C. A narrative, not to exceed two pages, discussing how the county is working on skills, development and strengthening of community organizations involved in providing essential services.

County Participation in State Initiative for Ethnically and Culturally Focused Community Based Organizations providing services to Adults and Children:

The Center for Multicultural Development (CMD) at the California Institute for Mental Health (CIMH) and the California Department of Mental Health formed a collaborative with the objectives of: 1) fostering successful partnerships between counties and ethnic and culturally focused Community-Based Organizations (CBOs) in the implementation of MHSA activities; and 2) providing strategies, training, and tools for developing organizational capacity of ethnic and culturally focused CBOs. The County of San Diego identified two agencies, Chaldean Middle Eastern Social Services (CMSS) and Survivors of Torture, International (SOTI) to participate in trainings by June 2010.

- The County of San Diego has been working closely with CMSS to develop and strengthen the structure of the MHSA funded program, to ensure a high quality of services. The goals of CMSS are to improve access to mental health services by persons with a serious mental illness who are Middle Eastern refugees, to increase the number of services available, to provide culture-specific services, and to provide case management and brokerage services. The program's comprehensive and integrated approach provides bio-psychosocial rehabilitation services which are recovery and strength based, client and family driven, and culturally competent. The County has provided on-site training and technical assistance by the Quality Improvement Unit to make sure services and documentation are within Medi-Cal regulations. The County has met with the Program Director on multiple occasions to have all policies and procedures developed in alignment with program structure and processes, including quality assurance activities. In addition, the County has provided assistance with budgeting and cost reporting activities.
- The County of San Diego has also worked directly with the MHSA funded SOTI program. The goals of SOTI are to improve access and increase the number of culture-specific services to persons who have been victims of trauma and torture, as well as to provide outreach and education services to the community. SOTI employs a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength-based, client and family driven, and culturally competent. Because many survivors of torture are in exile from their culture of origin, the term "culture" reflects both the client's culture of origin, as well as referring to the general "culture of fear" that develops in societies where torture is widespread. The County contract monitor meets with the program staff monthly to address any issues that arise and to develop and strengthen the skills of the organization to maintain contract compliance.

Other County Efforts to Strengthen Community Based Organizations:

Primary Care and Mental Health Services Integration programs include efforts with multiple primary care health centers to develop collaboration, capacity, and infrastructure to transition clinically stable mental health clients to primary care for treatment of co-occurring disorders. Eleven community health centers are participating to enhance capacity and infrastructure and facilitate the transition of clinically stable mental health clients to the primary care centers.

- Rural Health Initiative intends to develop extensive behavioral health prevention, education and intervention services within the context of several rural family practice clinics.
- Integrated Health Care Project (IHC-1) is a joint County Medical Services (CMS)/Mental Health (MH) pilot project that aims to pair a primary care clinic with a mental health clinic offering services to indigent clients. Stable seriously mentally ill (SMI) adult, older adult, and Transition Age Youth clients are referred to the clinic to establish a patient-centered medical home.
- The Physical Health Integration Project's purpose is to twin a primary care clinic and mental health clinic to provide a full continuum of care. Key facets of the project include (but are not limited to) embedding a Behavioral Health Consultant as part of the primary care team; an RN care coordinator as part of the mental health clinic site to identify and refer mental health clients in need of primary care treatment; an Alcohol and Drug counselor who works across sites to address co-occurring issues and to transition stable SMI clients from mental health clinics to primary care clinics.
- East County Integrated Health Access Project is a joint CMS/MHS pilot project aimed at improving access to CMS-funded primary care for current mental health clients. The County's East County Mental Health Clinic is currently identifying indigent clients that are presenting with various physical health issues and who are not eligible for Medi-Cal.
- Salud Project is part of a County initiative to reach out to the Hispanic community by working with community clinics to make mental health services available through physical health care providers. The focus is on improving health outcomes among Hispanic older adults with diabetes and co-occurring depression. Two community clinics (North County Health Services and San Ysidro Health Center in the South Region of the County) are contracted to provide the service, with an evaluation component being conducted by the University of California, San Diego (UCSD). The Salud program has three main components: 1) outreach work with Promotoras trained lay-persons who provide culturally appropriate outreach, referrals, and education; 2) utilizing the Tomando Control de su Salud Program (Stanford's Chronic Disease Self-Management Program); and 3) integrated care management of diabetes and depression in the clinical environment utilizing short-term, solution-oriented counseling (Problem Solving Therapy). In addition to providing the information and workshops in English and Spanish, there is a cultural adaptation piece being pursued, which is an effort to make Problem Solving Therapy more appropriate for Hispanic older adults.

National Alliance on Mental Illness (NAMI San Diego) has helped address the county's current relationship with, engagement with, and involvement of racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services, through the provision of the following culturally competent activities:

- Elder Multicultural Access and Support Services provides outreach to Latino Older Adults in the South, Central, and North Inland regions of the County with the goal of providing mental health prevention and early intervention services.
- Family to Family is a 12-week education program for families (offered in Spanish, Vietnamese, and Arabic) provides exhaustive information about mental illnesses, on understanding and supporting the relative living with the illness, as well as a wide array of coping skills.
- Peer-to-Peer provides a 10-week education program (for English and Spanish) for people living with mental illnesses.

- NAMI Support Groups which are offered in English and Spanish are open to family members and to all that need the assistance.

Housing for Mental Health Clients:

The Corporation for Supportive Housing (CSH), a County created organization, provides trainings and educational forums for housing developers and various other service providers to foster an understanding of the cultural dimensions of housing people with mental health issues. CSH's Fair Housing Training for Developers, for example, stresses not only the legal aspects of fair housing law requirements, but also the understanding of the various needs of the client population. CSH continues to be the conduit working between the housing developers or sponsors and the service providers to resolve complex issues regarding tenancy and the related supportive services. As an additional support for developers, the SDCMHS is funding a stigma and discrimination reduction campaign to help pave the way to introduce and establish housing for mental health clients in a community.

Children's Mental Health Efforts for Strengthening and Skill Building for Community Organizations:

The County of San Diego Children's Mental Health Services is working continuously towards skills development via:

- Children's System of Care Training Academy (CSOCTA).
- Collaborations with partners that include family members/representatives, youth, mental health case managers, probation officers, social workers, teachers, clinicians, preachers, and community representatives to create an integrated environment to increase the skills of the entire range of participants in the CSOC to better provide services to families and youth. The CSOCTA embraces the following principles:
    - ✓ Individualized: Creating services that fit
    - ✓ Strength based: Focusing on the positive
    - ✓ Integrated: Bridging systems of care
    - ✓ Outcome driven: Doing what works
    - ✓ Collaboration of four sectors: Families & Youth,, Public, Private, Education
    - ✓ Child/Youth focused, family centered: Respecting all voices
    - ✓ Community Based: Strengthening neighborhood resources
    - ✓ Culturally competent

and offers the "Principles to Practice Workshop" to providers in order to enhance daily skills with the goal of improving outcomes for children. This workshop will be available via web in the near future. Additionally, for the last nine years, the CSOCTA has been hosting an annual conference.

- The County of San Diego Children's Mental Health Family Youth Partner Employment Training Academy supports community-based organizations and agencies in advancing a family centered practice by employing family and youth partners.
- The County of San Diego Behavioral Health Services Training and Education Committee (BHSTEC) is planning a Children's Mental Health focused conference. The subject is being finalized, and will most likely focus on the 0-5 population.

Furthermore, County of San Diego Children's Mental Health Services provides Evidence Based Practices in many of its programs, for example:

- Palomar Family Counseling School Age Program provides social-emotional mental health evidence-based prevention and early intervention services for elementary school age underserved and living in high risk communities children based at four public schools in north San Diego County. The program includes:
    1) Positive Behavioral Support (PBS) implemented through the Building Effective Schools Together (BEST) model (Institute for Violence and Destructive Behavior, University of Oregon)

2) Incredible Years Parent, Teacher, and Child Training Series, a universal social-emotional evidence-based prevention practice that primarily targets pre-school through third grade children
3) Screening, early identification and early social-emotional intervention with at-risk children in the targeted public elementary schools.

Palomar Family Counseling Services also provides Motivational Interviewing and Incredible Years EBP's in their Childnet program that program targets Latino and Asian Pacific Islander children ages 0-5 and their families in the North County region.

Two new programs, funded in part through the Mental Health Services Act, target the underserved delinquent juvenile population, within which African American youth are disproportionately represented.

Starting in July 2009, Juvenile Forensic Services (JFS) transformed to include the Stabilization, Treatment, Assessment and Transition (STAT) team. This new service focuses on providing a full range of stabilization and transitional mental health services to emotionally disturbed probation youth. The goals of this service, in addition to providing crisis mental health services, are to maximize successful transition into the community, to reduce criminal recidivism and minimize negative mental health outcomes.

Juvenile Forensic Assistance for Stabilization & Treatment (JFAST) is a juvenile mental health court pilot which began in July 2010. The goals of this program are to promote rehabilitation with probation youth who are identified as being at risk for failure related to their mental illness, thereby improving probation outcome, public safety, and reducing recidivism.

HHSA's Building Better Health Program:

San Diego County Health and Human Services Agency's Health Strategy Agenda: Building Better Health supports the County direction on collaborating with community partners and businesses, as well as aligning County services to promote health (both physical and mental). Four major themes are identified that combined can affect the health of residents:

- Build a Better System
- Support Healthy Choices
- Pursue Policy Changes for a Healthy Environment
- Improve the Culture From Within

The theme of improving the culture from within focuses on increasing employee knowledge about health, promoting employee wellness, and implementing internal policies and practices that support employee health. Healthy County employees play a vital role in a healthier San Diego community.

D. Share lessons learned on efforts made on the items A, B, and C above.

In the design and development of services for culturally diverse groups, the lessons learned include the following:

- Building and developing relationships is a continuous and constant process to engage stakeholders through addressing common issues and concerns in a meaningful way.
- Meetings need to include key community leaders and representatives who can act as culture brokers and mediators. The meetings should be conducted in their own community.
- When engaging the community, we need to consider adjunct and complementary interventions that are common to the cultural and diverse groups that make up the community.
- Outreach and engagement strategies for ethnically and culturally diverse communities take a long time and, as a process, may require developing and accommodating to non-traditional ways to build relationships and to problem solve.

E. Identify county technical assistance needs.

The County will welcome technical assistance in the following area: the adaptation of clinical best practices or promising practices for culturally diverse groups to improve access to care and retention. For example, in San Diego, information on how to adapt best practices for Latinos, Asian/Pacific Islanders, Middle Easterners and Africans would be helpful.

COMMITMENT TO CULTURAL COMPETENCE

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

The CC/ESM will report to, and/or have direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

The county shall include the following in the CCPR:

A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

Twelve years ago in 1998, County of San Diego appointed Dr. Piedad Garcia as the Ethnic Services Manager who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural and linguistic populations.

B. Written description of the cultural competence responsibilities of the designated CC/ESM.

The Ethnic Services Manager (ESM) is the Assistant Deputy Director for Adult and Older Adult Mental Health Services (AOA). Dr. Garcia advises and directs planning, recommends policy, compliance and evaluation components of the county system of care. In her role as ESM, she makes recommendations to the MHS director to assure access and quality services for linguistically, ethnically, and culturally diverse groups. The ESM is the current Chair of the Cultural Competence Resource Team.

In her capacity as the Assistant Deputy Director she oversees a very large system of care that serves over 43,000 patients in an array of outpatient, rehabilitation and recovery services across San Diego County. Her direct report staff monitor, oversee, and ensure the provision of integrated mental health services and co-occurring disorder services that are culturally relevant and appropriate. Dr. Garcia takes lead responsibility for the development and implementation of cultural competence planning within the SDCMHS. She provides direction and oversight in the Adult/Older Adult System of Care for diversity-related contracted and directly operated services. She also oversees and participates in the monitoring of organizational providers to verify that the delivery of services is in accordance with local and State mandates as they affect underserved populations.

As an Executive Team member of the MHS Management and Leadership team, the Ethnic Services Manager makes program and procedure policy recommendations to the Mental Health Director and the Quality Improvement Unit. She also maintains close collaborative relationships with consumer and family organizations. An active advocate, she consults and has a supportive relationship with local planning boards, advisory groups and task forces, the State, and other mental health advocates. Most recently, Dr.

Garcia was selected to participate in the California Latino Mental Health Reducing Disparities Project - Latino Concilio which will be developing the Latino Health Care Disparities Strategic Plan for the Department of Mental Health.

COMMITMENT TO CULTURAL COMPETENCE

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities

EXAMPLES: BUDGET RESOURCES TARGETED FOR CULTURALLY COMPETENT ACTIVITIES--FY 08-09

Interpreter Services	$950,143
Chaldean Services	224,000
Victims of Torture	198,492
MH Services for Deaf, Hard of Hearing	246,312
Deaf Community Services	52,030
Client Operated Peer Support Services	548,400
Heritage Clinic for Older Adults	3,877,015
Union of Pan Asian Communities	1,037,125
Maria Sardinas Outpatient	1,169,110
Indian Health Council	642,000
School Based Services—MHSA Expansion est.	3,150,000
Cultural Access & Resource Enhancement	832,767
Providence Community Services for TAY	2,777,701
Outpatient MH Services for Deaf, Hard of Hearing Children/Youth	147,840
Community Assessment Team for Latino At Risk Youth	325,000
Outpatient MH Services for Ethnic Communities through UPAC	1,130.058

In addition to its ongoing programming, the SDCMHS started 40 programs through MHSA CSS funding and 30 programs through PEI to help address disparities and provide more culturally competent activities for persons with mental health problems.

B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

1. *Interpreter and translation services;*
2. *Reduction of racial, ethnic, cultural and linguistic mental health disparities; school based services and the Hispanic youth*
3. *Outreach to racial and ethnic county-identified target populations;*
4. *Culturally appropriate mental health services; and*
5. *If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.*

1. Interpreter and translation services

The awareness of interpreter services, the demand for these services, and the consequent funding allocation for interpreter services has continued to increase, as shown below.

FY	Number of Interpreter Services	Funding
09-10	12,810	1,138,482

08-09	9,254	881,556
07-08	7,828	748,031
04-05	3,362	

It should be noted that modest amounts of additional interpreter services are available through the SDCMHS 24/7 Access and Crisis Line, Jewish Family Service Patient Advocacy, etc. Translation services vary from year to year; translation costs have ranged from $2,000 to over $25,000, depending on the need for translating of all new materials or the need to modify existing materials.

2. Reduction of racial, ethnic, cultural and linguistic mental health disparities

To widen the access to children's services to increase access and reduce ethnic disparities, the SDCMHS began its drive to bring services to the community through the school based program. It was believed that minority groups would be more likely to be engaged because non-threatening treatment sites were established in local schools and parents could participate without having to find transportation. Starting with 7 schools in 1999, as EPSDT funding availability increased and MHSA CSS funding became available, the program has been expanded to over 350 schools throughout the County.

The penetration rate for Hispanic youth involved in mental health services rose from 3% in FY 01-02 to 5% in FY 006-07; it is expected that programs funded through MHSA will continue to result in an increasing penetration rate. The penetration rate for Asian/Pacific Islander children declined from 5% in FY 01-02 to 3% in FY 06-07, during a time of significant Asian immigration. The decline indicates less success in reaching the Asian population and being able to provide services targeted to new immigrant groups.

Among the cultural disparities the County addressed, age targeted services were started through MHSA to reach out to under-served and unserved populations of Transition Age Youth and Senior Citizens. A full-service partnership program was begun for Transition Age Youth which provided housing, treatment services and a dedicated clubhouse with more age-appropriate services ($2,777,701 spent in FY 08-08). Likewise, clinical, treatment and mobile outreach services were begun geared specifically for Seniors ($3,377,015 spent in FY 08-09).

The SDCMHS has also begun to address the service disparities for homeless culture. Several Assertive Community Action Programs (FSPs) have been started to help the homeless and those being released from jail get an appropriate level of care in the community, so that they can avoid costly inpatient and jail services.

3. Outreach to racial and ethnic county-identified target populations

Through PEI funding, outreach to racial and ethnic county identified target populations will be conducted, beginning with a large, multi-media anti-stigma and discrimination campaign. Approximately $5,000,000 has been allocated for this effort which is beginning in September, 2010.

The two following PEI programs target specific ethnic groups. The Elder Multicultural Access and Support Services (EMASS) PEI program is a peer-based outreach and engagement program targeted to Hispanic, African refugee, African American and Asian Pacific Islander older adults to support prevention of mental illness and increase access to care. The Salud Program targets

Hispanic older adults with the goal of integrating treatment of co-occurring health and mental health issues.

In addition, a special PEI program, Alliance for Community Empowerment, (ACE) is being implemented by Union of Pan Asian Communities (UPAC). Through ACE, approximately $1,500,000 is targeted toward victims of violence and trauma, a group which includes both recent immigrant populations and ethnicities dealing with gang and domestic violence. A second allocation of approximately $1,500,000 has been provided to pilot integrated mental and physical health services in the rural regions of the County with a high ethnic population, as a means of engaging clients in a non-threatening environment.

4. Culturally appropriate mental health services

All County and Contracted outpatient programs are required to be moving along a continuum toward providing culturally appropriate services. Such services currently include having staff with language capabilities matching the community needs to the maximum degree possible, creating a welcoming atmosphere, and providing free access to interpreter services. Some providers already have cultural competence plans in place, are moving toward proficiency testing of bi-lingual staff, and employing a self-examination test of their own agency cultural competence. Still other programs are targeted toward specific ethnic, age or cultural groups. In FY 09-10, the SDCMHS spent approximately $100,000,000 of its total budget on outpatient programs located on this continuum of providing culturally appropriate mental health services.

5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

County clinical staff who speak any of the threshold languages for San Diego, receive an additional hourly stipend. The SDCMHS strongly encourages its providers to consider a similar system to help in the attraction and retention of bi-lingual staff. At the current time, the SDCMHS is just beginning to develop relationships with non-traditional spiritual providers and does not have any contracts in place yet.

CRITERION 2

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

UPDATED ASSESSMENT OF SERVICES NEEDED

CRITERION 2 – UPDATED ASSESSMENT OF SERVICE NEEDS

UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

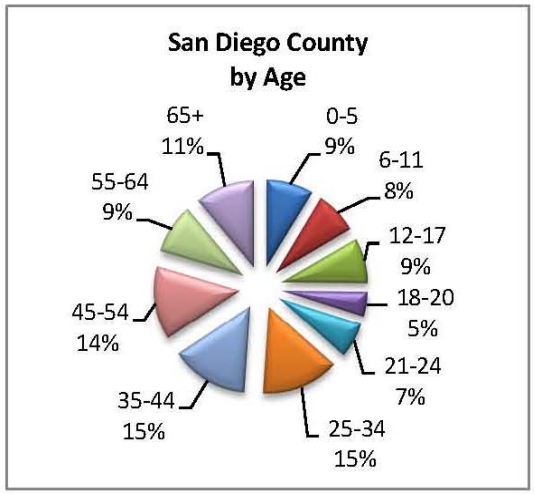
The county shall include the following in the CCPR:

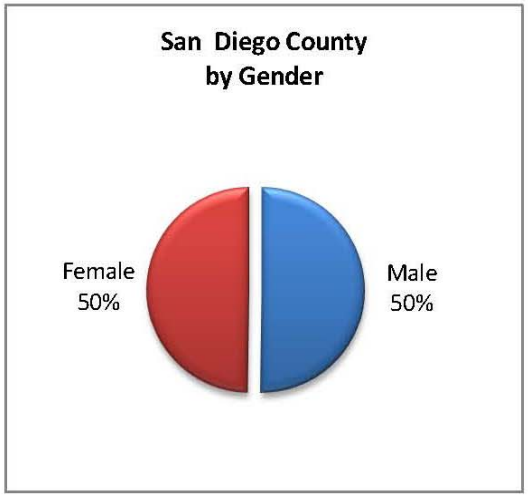
A. Summarize the county's general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

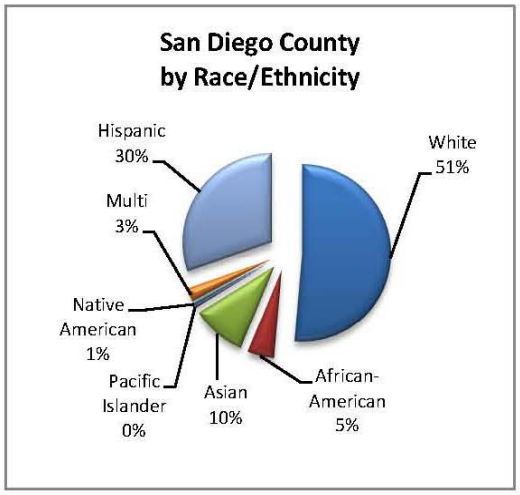
GENERAL POPULATION			BY YOUTH (0-17)/ ADULT (18+)	Population	%
ALL SAN DIEGO	2,974,859		YOUTH TOTAL	749,170	25.2%
AGE GROUP	Population	%	ADULT TOTAL	2,225,689	74.8%
0-5	260,325	8.8%	GENDER (youth)		
6-11	235,346	7.9%	Male	385,114	51.4%
12-17	253,499	8.5%	Female	364,056	48.6%
18-20	138,808	4.7%	GENDER (adult)		
21-24	198,706	6.7%	Male	1,109,013	49.8%
25-34	433,472	14.6%	Female	1,116,676	50.2%
35-44	435,693	14.6%	RACE/ETHNICITY (youth)		
45-54	410,899	13.8%	White	285,625	38.1%
55-64	277,290	9.3%	African-American	41,273	5.5%
65+	330,820	11.1%	Asian	63,628	8.5%
		100.0%	Pacific Islander	2,793	0.4%
GENDER (ALL)			Native American	3,904	0.5%
Male	1,494,127	50.2%	Multi	34,561	4.6%
Female	1,480,732	49.8%	Hispanic	317,387	42.4%
RACE/ETHNICITY (ALL)			RACE/ETHNICITY (adult)		
White	1,528,568	51.4%	White	1,242,943	55.8%
African-American	145,227	4.9%	African-American	103,954	4.7%
Asian	298,156	10.0%	Asian	234,528	10.5%
Pacific Islander	12,419	0.4%	Pacific Islander	9,626	0.4%
Native American	15,928	0.5%	Native American	12,024	0.5%
Multi	73,192	2.5%	Multi	38,631	1.7%
Hispanic	901,369	30.3%	Hispanic	583,982	26.2%

NOTE: **Language** data was not available in the CPES data source and therefore was not included in the above table.
Data source: CPES Estimates of Need for Mental Health Services For California, San Diego County (073). Chron MH imp7 D120-Agesq (w1xmhm2asq_3) for 2007.
http://psy.utmb.edu/CPES_htm/agesq07_htm/California/w1xmhm2asq_3_ca073.htm . (3/3/2009).

County of San Diego General Population by Age, Gender, and Race/Ethnicity, 2007







Summary of Population:

- San Diego County's General Population was split evenly between males and females, largely comprised of White (51%) and Hispanic (30%) persons, and fairly evenly distributed across age groups.

- When collapsing across age groups, we observed 17% Children ages 0-11, 9% Youth ages 12-17, 12% Transitional Age Youth ages 18-24, 53% Adults ages 25-64, and 11% Older Adults (65+).

Data source: CPES Estimates of Need for Mental Health Services For California, San Diego County (073). Chron MH imp7 D120-Agesq (w1xmhm2asq_3) for 2007. http://psy.utmb.edu/CPES_htm/agesq07_htm/California/w1xmhm2asq_3_ca073.htm . (3/3/2009).

UPDATED ASSESSMENT OF SERVICE NEEDS

II. Medi-Cal population service needs (Use current CAEQRO data if available.)

The county shall include the following in the CCPR:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

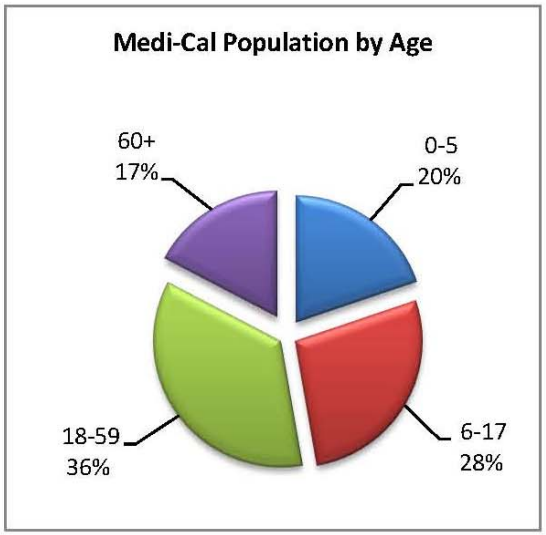
B. Provide an analysis of disparities as identified in the above summary.

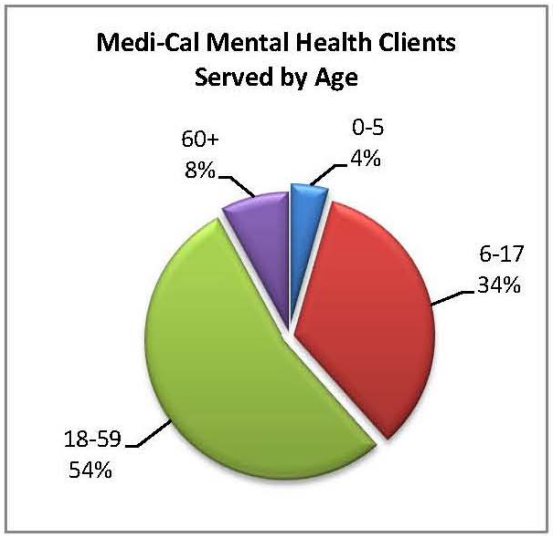
Note: *Objectives for these defined disparities will be identified in Criterion 3, Section III.*

MEDI-CAL BENEFICIARIES				
	Average Eligible/Month	% Eligible/Month	Unduplicated # Served/Yr	Served/Yr (%)
TOTAL	378,319	100.0%	31,844	100.0%
AGE GROUP				
0-5	74,873	19.8%	1,416	4.4%
6-17	103,893	27.5%	10,830	34.0%
18-59	134,125	35.5%	17,081	53.6%
60+	65,430	17.3%	2,517	7.9%
GENDER				
Male	160,666	42.5%	15,078	47.3%
Female	217,654	57.5%	16,766	52.7%
RACE/ETHNICITY				
White	85,958	22.7%	12,530	39.3%
Hispanic	181,027	47.9%	9,618	30.2%
African-American	37,350	9.9%	4,318	13.6%
Asian/ Pacific Islander	37,183	9.8%	2,116	6.6%
Native American	1,556	0.4%	258	0.8%
Other	35,248	9.3%	3,004	9.4%
SERVICE				
24 hour	378,319	100.0%	2,796	8.8%
23 hour	378,319	100.0%	1,170	3.7%
Day Treatment	378,319	100.0%	1,418	4.5%
Linkage/Brokerage	378,319	100.0%	8,124	25.5%
OP	378,319	100.0%	26,329	82.7%
TBS	378,319	100.0%	199	0.6%
Medication support	378,319	100.0%	19,032	59.8%

NOTE: Language data was not available in the EQRO data source and therefore was not included in the above table. Data Source: Medi-Cal Approved Claims Data for San Diego County MHP Calendar Year 08. Sourced from: DMH Approved Claims and MMEF Data - Notes (1) and (2). Date Prepared: 01/15/2010, Version 1.0 by Hui Zhang, APS Healthcare/ CAEQRO.

County of San Diego Mental Health Medi-Cal Population and Utilization by Age, 2008





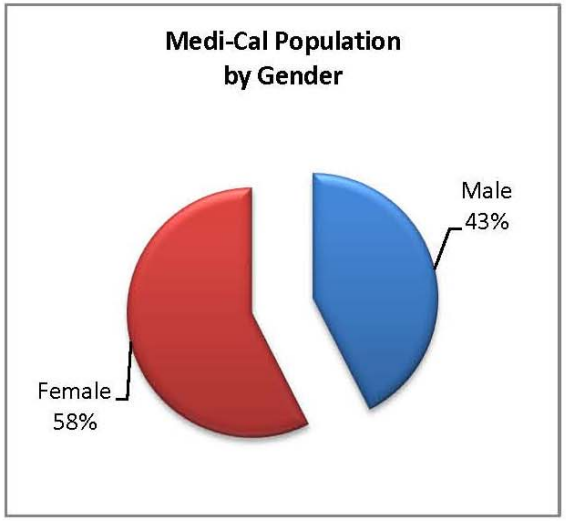
AGE	EQRO Average Eligible/ Month (%)	EQRO # Served/ Yr (%)
0-5	20%	4%
6-17	28%	34%
18-59	36%	54%
60+	17%	8%

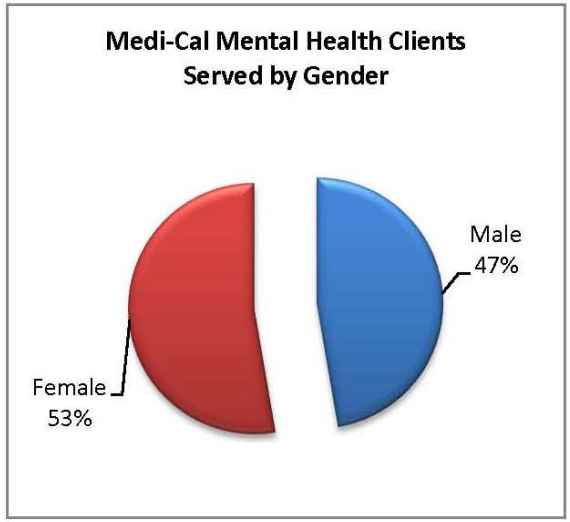
Disparities, and Analyses:

- Adults, although comprising 36% of the County's Medi-Cal population, received 54% of the Medi-Cal mental health services.
- Children, 28% of the County's Medical population, received 34% of the Medi-Cal mental health services.
- While young children ages 0-5 comprised 20% of the Medi-Cal population, they only received 4% of the County Medi-Cal mental health services. This potential under-representation is reflective, in part, of a population including some too young to be exhibiting diagnosable problems and of clinicians' discomfort with early labeling of small children.
- Older Adults, while 17% of the Medi-Cal population, receive only 8% of the services, appearing to be an underserved group. Difficulty accessing services because of transportation problems is believed to be one main of the causes of this disparity. Older adults in some racial/ethnic groups stigmatize having/receiving help for mental illness and may be unacquainted with concept of recovery from mental health problems.

Data Source: Medi-Cal Approved Claims Data for San Diego County MHP Calendar Year 08. Sourced from: DMH Approved Claims and MMEF Data - Notes (1) and (2). Date Prepared: 01/15/2010, Version 1.0 by Hui Zhang, APS Healthcare/ CAEQRO.

County of San Diego Mental Health Medi-Cal Population and Utilization by Gender, 2008





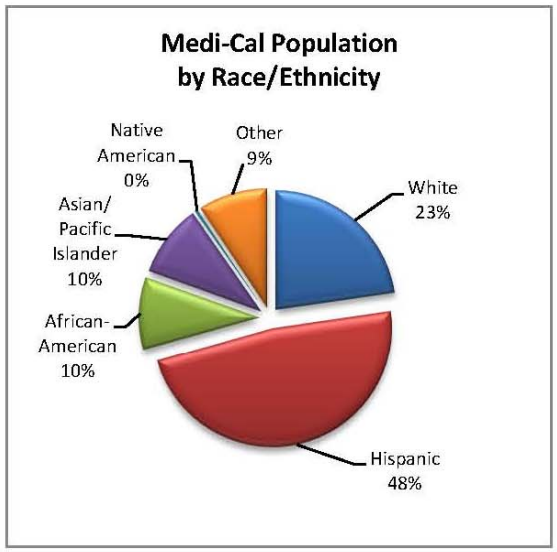
GENDER	EQRO Average Eligible/ Month (%)	EQRO # Served/ Yr (%)
Male	43%	47%
Female	58%	53%

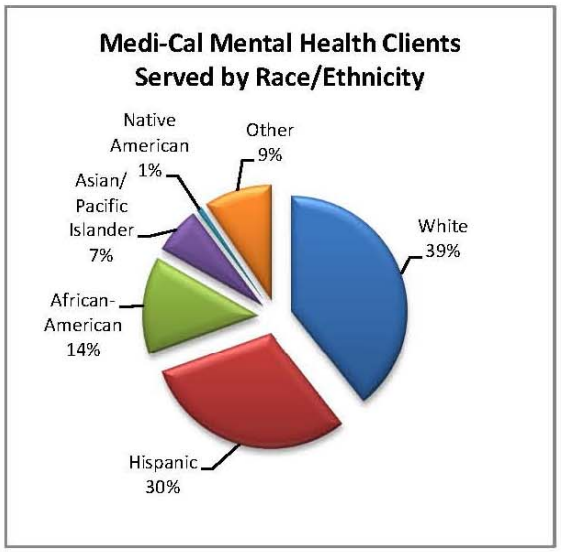
Disparities and Analyses:

- While the ratio of males to females in the County is about 50-50, the ratio among San Diego's Medi-Cal population and among recipients of County MH services have a higher percentage of females than males.
- 58% of those eligible for Medi-Cal services were female and 43% male.
- Among persons receiving Medi-Cal mental health services, the percentage of females was 5% lower (53%), while males comprised 47% of the population. These numbers are skewed by the Children's mental health population where 61% of the clients are males and 37% females (76% have Medi-Cal). The preponderance of male children in mental health services is related to boys' tending to externalize mental health problems versus females tendency to internalize.

Data Source: Medi-Cal Approved Claims Data for San Diego County MHP Calendar Year 08. Sourced from: DMH Approved Claims and MMEF Data - Notes (1) and (2). Date Prepared: 01/15/2010, Version 1.0 by Hui Zhang, APS Healthcare/ CAEQRO.

County of San Diego Mental Health Medi-Cal Population and Utilization by Race/Ethnicity, 2008





Race/ Ethnicity	EQRO Average Eligible/ Month (%)	EQRO # Served/ Yr (%)
White	23%	39%
Hispanic	48%	30%
African-American	10%	14%
Asian/ Pacific Islander	10%	7%
Native American	0%	1%
Other	9%	9%

Disparities and Analyses:

- White persons and African-American persons represented a larger portion of those served than those eligible for services. Specifically, White persons made up 23% of those eligible and 39% of those served. African-American persons made up 10% of those eligible and 14% of those served.
- Hispanic and Asian/Pacific Islander groups appear to be underserved. Specifically, 48% of the eligible population was Hispanic, but only 30% of those served were Hispanic. Asian/Pacific Islander made up 10% of the Medi-Cal population, but only 7% of those served.

Data Source: Medi-Cal Approved Claims Data for San Diego County MHP Calendar Year 08. Sourced from: DMH Approved Claims and MMEF Data - Notes (1) and (2). Date Prepared: 01/15/2010, Version 1.0 by Hui Zhang, APS Healthcare/ CAEQRO.

UPDATED ASSESSMENT OF SERVICE NEEDS

III. 200% of Poverty (minus Medi-Cal) population and service needs

The county shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally.)

B. Provide an analysis of disparities as identified in the above summary.

Note: *Objectives will be identified in Criterion 3, Section III.*

CPES CY2007/CAEQRO CY2008							SAN DIEGO
	CPES Population	Medi-Cal Eligible (EQRO)	<%200 poverty minus Medi-Cal	CMH SERVED	Medi-Cal SERVED (EQRO)	<%200 poverty minus Medi-Cal SERVED	Penetration Rate
ALL SAN DIEGO	881,768	378,319	**503,449**	58,741	31,844	**26,897**	5.3%
AGE GROUP							
0-5	109,752	74,873	**34,879**	1,847	1,416	**431**	1.2%
6-17	190,243	103,893	**86,350**	14,975	10,830	**4,145**	4.8%
18+	581,773	199,555	**382,218**	41,919	19,598	**22,321**	5.8%
GENDER (ALL)							
Male	414,761	160,666	**254,095**	31,374	15,078	**16,296**	6.4%
Female	467,007	217,654	**249,353**	26,723	16,766	**9,957**	4.0%
RACE/ETHNICITY (ALL)							
White	271,190	85,958	**185,232**	25,623	12,530	**13,093**	7.1%
Hispanic	449,336	181,027	**268,309**	18,138	9,618	**8,520**	3.2%
African-American	51,112	37,350	**13,762**	7,671	4,318	**3,353**	24.4%
Asian/Pacific Islander	79,765	37,183	**42,582**	2,792	2,116	**676**	1.6%
Native American	5,387	1,556	**3,831**	376	258	**118**	3.1%

NOTE: Language data was not available in either the CPES or EQRO data sources and therefore was not included in the above table.

The Multi/Other Category has been eliminated from the above table because the computations needed to produce the <200%Poverty minus Medi-Cal Population produced a negative number. Specifically, the reported number of persons eligible for Medi-Cal in the EQRO data was larger than the number of persons reported in the <200%Poverty Population in the CPES data. The computation, in this particular case, is not appropriate.

Data Sources: CPES Estimates of Need for Mental Health Services For California, San Diego County (073). Chron MH imp7 D120-Agesq (w1xmhm2asq_3_ for 2007. http://psy.utmb.edu/CPES_htm/agesq07_htm/California/w1xmhm2asq_3_ca073.htm (3/3/2009). AND Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 08. Sourced from DMH Approved Claims and MMEF Data - Notes (1) and (2). Prepared by Hui Zhang, APS Healthcare/ CAEQRO (01/15/2010, Version 1.0).

County of San Diego Mental Health Combined Population and Service Needs.

In planning for services, the County of San Diego Mental Health Services has found it more useful and reflective of the County's population to consider the combined needs of the Medi-Cal and Indigent populations, since fully 45% of the adult MH population and 15% of the children's MH population are uninsured. (Adults comprise about 70% of the total Mental Health population.) Additionally, the County, through its UCSD Research Centers (the Child and Adolescent Services Research Center and the Health Services Research Center) is able to put together more definitive statistics on its population and services usage than can be provided by the State.

To understand the needs of the whole County mental health population for MHSA planning, the SDCMHS and its USCD Research Centers conducted the Gap Analysis and created a disparities report," Progress Towards Reducing Disparities: A Report for San Diego County Mental Health, Five Year Comparison FY 2001-2001 to FY 2006-07". (Copies of these reports are included in the Appendix, Criterion 2.III.pp.B.1-81) These reports provide more definitive information by age, ethnicity, and language of choice, service usage, and diagnosis to build on the State information. The Gap Analysis and Disparities Report show the following disparities:

Latino Adults may be underserved and not as easily engaged

- 31% of Hispanic adult clients identified Spanish as their preferred language
- Only 19% of adult clients served were Hispanic, while the County population was 30%
- 13% of adults had only one visit to an outpatient program
- 45% of adults had fewer than 8 visits
- Clients were less likely to use Forensic services that the overall Mental Health population

Latino Children may be underserved and not as easily engaged

- Had among the lowest penetration rates in FY 2006-07, although it had increased since FY 2001-2. The proportion of Latino children in the County population continues to increase, going from:
- Almost 30% identified Spanish as their preferred language
- Approximately half the children receiving MH services identify themselves as Hispanic
- 30% had fewer than 5 visits to outpatient services; of that group 12% had only 1 visit

African American Adults may be underserved and/or not as easily linked with less acute levels of care.

- Were more likely to use only inpatient/emergency services (18%) and only jail services (27%) and less likely to use outpatient services than other racial/ethnic groups
- Had a high rate of diagnosis with Schizophrenia or Schizoaffective disorder
- 45% of the clients are female and 53% male

African American Children may be under-served and/or not as easily linked with less acute levels of care

- Were more likely to use juvenile forensics services without using any other type of less restrictive services than other racial/ethnic groups
- Were more likely to use Day Treatment Services--a comparatively intensive treatment modality

- 13% had only 1 visit to outpatient services

Asian/Pacific Islander Adults were underserved

- 41% identified an Asian language as their preferred language
- 54% of clients were female and 46% male
- Had moderate to low access rates compared to most other racial/ethnic groups; the rates have gone up slightly over time.

Asian/Pacific Islander Children were underserved

- Had low access rates compared to other racial/ethnic groups and the rates have gone down slightly over time.
- Had the lowest engagement rate and were most likely to discontinue services after 1 visit
- 16% had only 1 visit
- However, 89% identified English as their preferred language, 3% identified Vietnamese, and 7% assorted other languages.

Native American Adults

- Had among the second lowest access rates, although the rate has increased slightly over time.
- 96% identified English as their preferred language
- 56% of the clients were female and 44% male

Native American Children were underserved and not as easily linked with less acute levels of care

- Had the lowest access rate among racial/ethnic groups and there was a slight decline over time.
- Were most likely to use inpatient only services

<u>Other Factors Affecting Children's Usage of Mental Health Services</u>

- 20% of children receiving mental health services were also involved with Child Welfare Services and 36% were receiving Special Education services.
- 24% of children 12-17 used juvenile forensic services only.
- 18% of all CMHS clients were also open to the Probation System.
- Transitional Age Youth had the lowest access rates among age groups and their access to services declined slightly over time.
    - 31% had 3 or fewer visits to outpatient services.
    - Were more likely to use inpatient/emergency services (24%) and jail services (26%) and less likely to outpatient services.

The Gap Analysis and Disparities Report provided the foundation for determining service priorities for the CSS Plan, the WET Plan and the PEI Plan.

UPDATED ASSESSMENT OF SERVICE NEEDS

IV. MHSA Community Services and Supports (CSS) population assessment and service needs

The county shall include the following in the CCPR:

A. *From the county's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age and gender (other social/cultural groups may be addressed as data is available and collected locally*).

From Original CSS Plan:
Section II, Part II: Analyzing Mental Health Needs in the Community

SDMHS prepared a detailed gap analysis to fully understand the scope of mental health needs among all four target population age groups. The Gap Analysis, which included estimates of unserved, underserved and inappropriately served individuals, was provided to, reviewed, and discussed by the MHSA Workgroups.

1. Unserved Populations in San Diego County

The formula used to determine the number of unserved individuals in San Diego County was based on the estimated prevalence of mental health needs among those in poverty, for all age groups, across each ethnic classification, contrasted to the numbers served in the current service system.

In addition, as suggested in the CSS Requirements, SDMHS included the number of individuals who received inpatient or emergency services (stated in DMH requirements as crisis only) and no other mental health services in the estimate of the unserved. Another factor considered was the estimated numbers of homeless. These data were provided by the San Diego Task Force on the Homeless.

As can be seen in the figures below, significant ethnic/racial disparities exist among numbers of persons expected to need services, compared to those receiving services in today's system. In addition to the notable disparities demonstrated in the data, these findings were re-affirmed through the community input provided by family members, providers and other interested community stakeholders.

Estimates for Unserved Populations in San Diego County

1. 15,821 Children and Youth (0-17)
    - Of these, the primary racial/ethnic groups who are unserved are Latinos (8,805) and Asian Pacific Islanders (1,447); and
    - In addition to the ethnic/racial disparities, as many as 1.896 uninsured children may need mental health services and are currently unserved.

2. 8,900 Transition Age Youth (TAY) (between18 and 25)
    - In San Diego County, the unserved TAY are identified as between ages 18 and 25 years of age because there is no apparent service gap for 16 and 17 year olds.
    - Of this unserved group, the primary ethnic/racial disparity groups are Latinos (2,506) and Asian Pacific Islanders (312);
    - In addition, 1,127 youth utilized only crisis or emergency services, indicating needs for higher levels of services.

3. 16,007 Adults (25-59)
    - The majority of the unserved adults come from two primary ethnic/racial disparity groups: Latinos (9,422) and Asian Pacific (1,970)
    - 4615 adults utilized only emergency or inpatient mental health services, indicating need for community-based intensive services in order to prevent these occurrences.
    - Native Americans were much more likely to be in this category than expected, based on their prevalence in the general population;
    - In addition, there are an estimated 11,000 adults without insurance who may need mental services and who are currently unserved. We received significant community input about the need to expand culturally competent services for these groups.
    - As a result of community input, SDMHS will track service use by Transitional Age Adults ages 50-59 years of age to better understand mental health needs among this population.

4. 4,613 Older Adults (60+)
    - 578 older adults received only emergency or inpatient services, but were not connected to other services;
    - Prevalence estimates will be evaluated on an ongoing basis because the MHSA Older Adult Workgroup felt the prevalence estimates were too low, as stigma and isolation contribute to more underreporting and lack of recognition of mental illness among older adults.

2. Chart A. Service Utilization by Race/Ethnicity

The tables below provide estimates of the total number of persons needing MHSA-level mental health services who already are receiving services, including those fully served or underserved/inappropriately served, by age group, race ethnicity, and gender.

Transition Age Youth 18-24	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	5	0	746	574	5409	100%	130,559	100%	337,506	100%
RACE/ETHNICITY										
African American	2	0	102	52	626	11.6%	8935	7%	20,623	6%
Asian Pacific Islander	0	0	35	26	259	4.8%	12660	10%	35,965	11%
Latino	1	0	209	129	1,579	29.2%	53620	41%	122,665	36%
Native American	0	0	9	3	32	.6%	1611	1%	2,147	1%
White	1	0	349	239	2,567	47.5%	48699	37%	143,093	42%
Other (and UK)*	1	0	42	125	346	6.4%	5034	4%	13,013	4%

** Other includes other, unknown and 2 or more races*

*** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages 18+*

**** Fully served are those receiving Wraparound or AB2034 services according to DMH guidelines*

Adults 25-59	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	261	184	4004	3949	30,776	100%	347,997	100%	1,917,017	100%
RACE/ETHNICITY										
African American	46	39	583	558	3,656	11.9%	19618	6%	78,404	4%
Asian Pacific Islander	10	11	174	190	1,626	5.3%	26,296	8%	164,799	9%
Latino	30	25	748	793	5,993	19.5%	127502	37%	390,659	20%
Native American	0	3	22	33	189	0.6%	1432	0%	7,896	0%
White	166	103	2300	2211	16,549	53.8%	87216	25%	803,549	42%
Other*	9	3	177	164	2,763	9.0%	85531	25%	471,710	25%

Older Adults 60+	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	14	15	175	373	577	100%	96,530	100%	434,147	100%
RACE/ETHNICITY										
African American	2	2	17	40	186	6.7%	4676	5%	14,248	3%
Asian Pacific Islander	0	0	7	16	197	7.1%	9482	10%	40,446	9%
Latino	0	2	29	74	420	15.1%	21908	23%	56,392	13%
Native American	0	0	1	0	7	0.3%	414	0%	1,856	0%
White	12	10	107	226	1,571	56.6%	58922	61%	314,353	72%
Other*	1	1	14	17	393	14.2%	1530	2%	6852	2%

** Other includes other, unknown and 2 or more races*

*** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages 18+*

**** Fully served are those receiving Wraparound or AB2034 services according to DMH guidelines.*

B. Provide an analysis of disparities as identified in the above summary.

Analysis of Ethnic Disparities in Fully Served, Underserved or Inappropriately Served Populations in San Diego County

The populations continue to have disparities in mental health services in San Diego County. The disparities and variations in penetration rates and retention rates continue to be addressed through training, staffing, evidence-based practices, program evaluation, etc. Specific programs have been developed through MHSA to increase services to these populations.

Latinos

The gap analysis data point to a clear need to increase access to care for Latino children, TAY, adults, and older adults who live in poverty. Latino females, as compared to males, are under-represented in both children and TAY age groups. There is no gender gap among adult Latinos. According to the data, older adult Latino males are under-represented. Latino children who are fully served in the Children's System of Care/Wraparound Services program represent approximately 27 percent of all fully served. Latino fully served adults and older adults in the REACH program represent only 12 percent of all fully served population of the REACH program.

Asian/Pacific Islanders

The Asian/Pacific Islander population is under-represented in the public mental health system, comprising 8 percent of the target population and only 5 percent of current mental health clients. This need is complex, and poses a challenge to the mental health system because the grouping of Asian/Pacific Islanders is composed of many linguistically and ethnically diverse groups. This umbrella group includes Amerasian, Cambodian, Chinese, Filipino, Hawaiian Native, Hmong, Japanese, Korean, Laotian, Pacific Islander, and Vietnamese.

African Americans

The African-American general population is expected to stay relatively constant at 5-6 percent, yet they are over represented in acute inpatient care, in the juvenile forensic system and in adult jail mental health services. They are also more likely to receive a diagnosis of schizophrenia and are more likely to be male.

Native Americans

While there may not be a substantial difference between Native Americans served and the county's Native American population, San Diego County is home to 17 reservations, composed of numerous tribal groups. The SDMHS gap analysis (Attachment 14) noted that Native American children compose 1 percent of the children's mental health system, yet have varying rates of contact with other systems:

- They represent 1.6 percent of the mental health clients concurrently receiving Child Welfare Services;
- 3.2 percent are concurrently receiving services in Alcohol & Drug Services; and
- 0.2 percent of the children concurrently open to Juvenile Forensic Services.

These data on involvement in other systems may reflect inappropriately served populations that may benefit from mental health services.

Veterans

There are a substantial number of veterans who are seriously mentally ill and are in need of comprehensive mental health services. The MHSA Community Services and Supports programs will include, throughout its service array, all veterans who meet the MHSA and DMH guidelines.

UPDATED ASSESSMENT OF SERVICE NEEDS

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations

The county shall include the following in the CCPR:

A. Which PEI priority population(s) did the county identify in their PEI plan? The county could choose from the following six PEI priority populations:

1. *Underserved cultural populations*
2. *Individuals experiencing onset of serious psychiatric illness*
3. *Children/youth in stressed families*
4. *Trauma-exposed*
5. *Children/youth at risk of school failure*
6. *Children/youth at risk of experiencing juvenile justice involvement*

All six of the Priority Populations were identified in San Diego County's PEI Plan. Twenty PEI Project Work Plans were submitted and each one identified at least one of the Priority Populations and most addressed at least two or three. San Diego County identified 10 priority populations based on community member input; most of these are contained within the broader six listed above. These are as follows: Older Adult Issues ; Community and Domestic Violence; School Age; Early Childhood Services; Veterans and their Families; Native American Communities; Rural Community Issues; Co-occurring Disorders; First Break of Psychosis/Transition Age Youth; Primary and Secondary Prevention through outreach, education and media campaigns.

B. Describe the process and rationale used by county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

The County of San Diego utilized community input from the CSS Planning process, data from the Gap Analysis, and ongoing community input through our sustained Stakeholder-led Councils (Children's System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council, and Mental Health Board). From this community-based input, San Diego County developed eight focus areas: Native American Communities, Veterans and their Families, Co-Occurring Disorders, School Age and Early Childhood, Community and Domestic Violence, First Break of Psychosis, Rural Community Issues (East County, North Inland, Mountain Regions), and Older Adult Issues. A September 2007 "Kickoff Forum," co-facilitated by the Director of Behavioral Health Services and the Mental Health Services Deputy Director, introduced these eight PEI areas of focus and the PEI planning process to the larger community.

The MHSA Planning Team and MHS staff then organized eight community-based forums throughout the county for the purpose of soliciting stakeholder input within each of the focus

areas. These community forums, each of which was facilitated by a lead member from the PEI Planning Team or staff support team, took place from November 2007 through March 2008.

During the same time the "Kickoff Forum" and the community forums were taking place, Dr. Hanger, ADD in charge of the MHSA Plan and members of the PEI Planning Team attended numerous existing community-based stakeholder meetings as part of the outreach campaign to present and outline the PEI planning process, guidelines and timeline and engage community members in the planning process. Between July 2007 and April 2008 the MHSA Planning Team members and support staff participated in over 60 stakeholder meetings across six regions within San Diego County covering a variety of cultural and ethnic communities and age-ranges.

These stakeholder meetings included our ongoing Mental Health Councils, the constituency of which includes consumers, family/caregivers, providers, community experts, public agencies (City and County), education representatives, as well as open membership from local stakeholders. These Councils are chaired by members of the stakeholder community – not by Mental Health staff. Additional ongoing community meetings included community commissions (e.g., Children Youth and Family Commission, Domestic Violence Commission), which are similarly comprised of consumers, professionals, providers (public and private), interested community members, and designees from political offices.

Finally, thirty focus groups were convened specifically to obtain further stakeholder input from the immigrant, African Refugee, African American, Asian/Pacific Islander and LGBTQ communities, as well as other unserved and underserved populations. To ensure stakeholder input was also received from those with serious mental illness and serious emotional disturbances, focus groups were also facilitated in client clubhouses and an adult day health center. Separate from these public meetings, community and stakeholder input was solicited and received in a variety of formats including phone messages, website submissions (the County maintains an ongoing website, www.sandiego.networkofcare.org, which includes a section dedicated to disseminating information related to our MHSA planning process), e-mail and mail (PEI Community Input Forms, memos, letters, and full proposals). The information received was compiled for public review in a more "consumable" PEI Community Input Summary document.

All summary documents incorporating community input were posted on the County of San Diego's Behavioral Health Network of Care website for public information and review. In addition, these summary documents were sent to all members in our continually expanding e-mail distribution list of consumers, professionals, agencies, and other interested parties. All community/stakeholder input received to date, as well as summary documents prepared by the PEI Planning Staff, were also presented in an open, public session of our April 2008 Mental Health Board. The Mental Health Board serves as the initial cross-threading work group, as they are a non-conflict body of existing consumers and other stakeholders. Given the "contracting" nature of our County's mental health services, the issue of "conflict" had been previously resolved during the CSS planning process by our County's requiring the absence of fiscal conflict as a condition of cross-threading membership.

Following additional community input received during the public comment period, the April 2008 Mental Health Board provided a ranking of key community needs and priority populations. These rankings were taken up further by 10 workgroups consisting of a County Mental Health Chief, Regional Program Coordinator, or Assistant Deputy Director as lead, pertinent inter-Agency County staff, non-conflict community experts, and non-conflict consumers and stakeholders.

(During the stakeholder input process, community members had recommended separating School Age and Early Childhood Services into two separate focus tracts for further detailed planning.

Additionally, in the majority of the forum and focus groups, input was received recommending that the County address universal ("primary") prevention needs of suicide risk and stigma and discrimination, as well as targeted ("secondary") prevention for focus populations, within a separate work group. These workgroups scrutinized community input, relative data, and Mental Health Board rankings, as well as holding intensive meetings to develop PEI plans.

CRITERION 3

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

CRITERION 3 – STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

I. Identified unserved/underserved target populations (with disparities):

The county shall include the following in the CCPR:

- *Medi-Cal*
- *Community Services and Supports (CSS) population: Full Service Partnership (FSP) population*
- *Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce*
- *Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations*

A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations)

IDENTIFIED TARGET POPULATIONS WITH DISPARITIES BY PLAN

IDENTIFIED UNDER-SERVED/UNSERVED TARGET POPULATIONS (WITH DISPARITIES)	MEDI-CAL	200% Poverty minus Medi-Cal	SD COUNTY COMBINED MEDI-CAL AND POVERTY POPULATIONS *	CSS (INCLUDING FSP)	WET	PEI
Latino Adults/Older Adults	X	X	X	X	X	X
Latino Children	X	X	X	X	X	X
African American Adults	X		X	X	X	X
African American Children	X		X		X	X
Asian/Pacific Islander Adults/Older Adults	X	X	X	X	X	X
Asian/Pacific Islander Children	X	X	X	X	X	X
Native American Adults			X	X		X
Native American Children			X	X		X
Whites			X	X		
Children 0-5	X		X		X	X
Children 6-12	NA		X	X	X	X
12-17 yrs			X	X	X	X
Transitional Age Youth 18-24 yrs	X		X	X	X	X
Adults 25-59 yrs	X		X	X	X	X
Older Adults 60+ yrs	X		X	X	X	X
Females			X	X		
Males	X		X	X		
Veterans				X		X
GLBT				X		X
Recent Immigrants, Victims of Violence				X	X	X

The PEI Target Populations selected by San Diego include all of the following on the State list:

1. Underserved cultural populations
2. Individuals experiencing onset of serious psychiatric illness
3. Children/youth in stressed families
4. Trauma-exposed
5. Children/youth at risk of school failure
6. Children/youth at risk of experiencing juvenile justice involvement

Through the County PEI Planning Process, as disparities were recognized, the following more focused designations were included in the six target populations listed above:

- Adult, older adult, transition age youth
- Native American
- Veterans, retired military, reservists and their families
- Hispanic
- African American
- African refugee

A1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities)

"…The County of San Diego utilized community input from the CSS Planning process, data from the Gap Analysis, and ongoing community input through our sustained Stakeholder-led Councils (Children's System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council, and Mental Health Board). Using this evolutionary process, from this community-based input, San Diego County developed eight focus areas: Native American Communities, Veterans and their Families, Co-Occurring Disorders, School Age and Early Childhood, Community and Domestic Violence, First Break of Psychosis, Rural Community Issues (East County, North Inland, Mountain Regions),and Older Adult Issues. All of the identified issues can be folded into the six State target populations.

A September 2007 "Kickoff Forum," introduced these eight PEI areas of focus and the PEI planning process to the larger community. The MHSA Planning Team and MHS staff then organized eight community-based forums, between November 2007 and March 2008, throughout the county for the purpose of soliciting stakeholder input within each of the focus areas.

During the same timeframe, Dr. Hanger and members of the PEI Planning Team attended numerous existing community-based stakeholder meetings as part of the outreach campaign to present and outline the PEI planning process, guidelines and timelines and engage community members in the planning process. Between July 2007 and April 2008 the MHSA Planning Team members and support staff participated in over 60 stakeholder meetings across six regions within San Diego County covering a variety of cultural and ethnic communities and age-ranges. Finally, thirty focus groups were convened specifically to obtain further stakeholder input from the immigrant, African Refugee, African American, Asian/Pacific Islander and LGBTQ communities, as well as other un-served and underserved populations. To ensure stakeholder input was also received from those with serious mental illness and serious emotional disturbances, focus groups were also facilitated in client clubhouses and an adult day health center.

In addition to these public meetings, community and stakeholder input was solicited and received in a variety of formats including phone messages, website submissions, e-mail and mail. The information received was compiled for public review in a more "consumable" PEI Community Input Summary document, posted on the County of San Diego's Behavioral Health Network of Care website for public information and review and was sent to all members in our continually expanding e-mail distribution list of consumers, professionals, agencies, and other interested parties.

All community/stakeholder input received to date, as well as summary documents prepared by the PEI Planning Staff, were also presented in an open, public session of our April 2008 Mental Health Board. The Mental Health Board serves as the initial cross-threading work group, as they are a non-conflict body of existing consumers and other stakeholders. Given the "contracting" nature of our County's mental health services, the issue of "conflict" had been previously resolved during the CSS planning process by our County's requiring the absence of fiscal conflict as a condition of cross-threading membership.

Following additional community input received during the public comment period, the April 2008 Mental Health Board provided a ranking of key community needs and priority populations. These rankings were taken up further by ten workgroups consisting of a County Mental Health Chief, Regional Program Coordinator, or Assistant Deputy Director as lead, pertinent inter-Agency County staff, non-conflict community experts, and non-conflict consumers and stakeholders. (During the stakeholder input process, community members had recognized the great differences between the 0-5 population and older children and recommended separating School Age and Early Childhood Services into two separate focus tracts for further detailed planning. Additionally, in the majority of the forum and focus groups, input was received recommending that the County address universal ["primary"] prevention needs of suicide risk and stigma and discrimination, as well as targeted ["secondary"] prevention for focus populations, within a separate work group. Thus, eight focus issues became ten priority focus area workgroups.*) These workgroups scrutinized community input, relative data, Mental Health Board rankings, and held intensive meetings to develop PEI plans.

Existing consumer and family liaison agencies, whose members attended PEI Planning Meetings, also played key roles in creating additional opportunities for including representatives and family members of un-served and underserved populations in the participation process. Between February and March 2008, approximately 30 focus groups coordinated in partnership with community-based agencies were facilitated by these consumer and family liaisons, community members and County staff. Each focus group consisted of 6 to 15 participants and included consumers and family members. Smaller than community forums, these focus groups were specifically designed to foster a welcoming, inclusive environment for individuals from un-served and underserved communities, and to provide intentional, targeted opportunities for their input to be included in the planning process. In total, approximately 250 community members participated in focus groups representing a diverse group of individuals from a variety of un-served and underserved communities including, but not limited to, youth, LGBTQ, and various ethnic and cultural communities e.g., Latino, Asian/Pacific Islander, Eastern European, African-American, Refugee and Immigrants (see Section 2.b. for a fuller explanation of how two liaison agencies, Family & Youth Roundtable and Partners in Care, facilitated both representatives' and family members' involvement through targeted focus groups as well as attachment, "List of Focus Groups & Forums" detailing the diversity of the these focus groups)."

* As indicated in Q. 1, the ten population groups identified by the broad array of PEI community input groups can be condensed into the six State population targets, with San Diego County giving more detail about the composition of additional groups to include Native Americans, Veterans and their families, and African refugees.

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

II. Identified disparities (within target populations):

The county shall include the following in the CCPR:

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI priority/target populations).

Client Disparities--The SDCMHS has created the table below summarizing client disparities found by age, race/ethnicity, and other cultural grouping for the Medi-Cal population, the San Diego Combined Medi-Cal and <200% Poverty population (minus Medi-Cal), and the MHSA's CSS, WET and PEI populations.

IDENTIFIED UNDER-SERVED/UNSERVED TARGET POPULATIONS	MEDI-CAL	SAN DIEGO COMBINED MEDI-CAL AND <200% POVERTY (MINUS MEDI-CAL)	COMMUNITY SERVICES AND SUPPORT	WORKFORCE ENHANCEMENT & TRAINING	PREVENTION AND EARLY INTERVENTION
	DISPARITIES NOTED	DISPARITIES NOTED	DISPARITIES NOTED	DISPARITIES NOTED	DISPARITIES NOTED
Latino Adults/Older Adults	Older Adults underserved. Identified as underserved ethnicity.	31% identified Spanish as preferred language Underserved: Only 19% SDCMHS clients are Hispanic adults Poor engagement: 45% of clients>8 visits, 13% only 1 visit Older Adults under-served	Under–served, especially those living in poverty Latino fully served adults and older adults are12% of clients in the AB2034/REACH program	Need for 245 language proficient providers to meet projected need. Licensed staff positions were difficult to fill because of scarcity of candidates and non-competitive salaries.	Under-served population from Gap Analysis
		0-5 underserved 30% identified Spanish as ferred language gement: 30% 2% had 1	0-5 underserved Latino fully served children with Wraparound services=27% of all fully served. Latino children concurrently seen by MH and Special ation (37%) were under- as compared with ulation	See above	Under-served population from Gap Analysis
				African American staff is	**Added through**

See complete Table in Appendix, Criterion 3, pp. 3.II.A.1-5

Staffing Disparities -- noted in the WET Needs Assessment

- Unlicensed Direct Staff positions remained vacant primarily as a result of both non-competitive salaries and the unique qualifications needed for these positions; whereas Licensed Direct Staff positions were difficult to fill due to noncompetitive salaries and requirements for bilingual staff, primarily Spanish;
- Qualified clinical supervisor positions were identified as hard-to-fill, especially professionals with LCSW or MFT licensure;
- Hospitals and clinics are struggling from the overall shortage of nurses available in the county;
- Several positions have been vacant for over a year, particularly in rural areas or positions requiring licensed bilingual capability;

- Intense competition exists in the community for bilingual professionals and bilingual clinical positions;
- Positions are difficult to fill because salaries remain below community standards;
- Latinos and African Americans are under-represented in mental health staffing;
- There is a need for positions designated for individuals with consumer and/or family member experience;
- There is a need for Language Proficiency of staff in the following languages: Spanish, Tagalog, Vietnamese, Arabic, Russian, Cambodian, ASL, Lao, Somali and Swahili.

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.

The SDCMHS adopted the following strategies as the basis of planning for services and program expansion as each phase of the MHSA was rolled out:

CSS Plan Strategies/Actions/Objectives/Timelines

The CSS Plan identified the following Strategies/Objectives for the Provision of Culturally and Linguistically Competent Services to Address Disparities in Access to Care:

Based on the evident disparities in access to care for the ethnically diverse groups noted and listed in the previous question, SDCMHS committed to continuing expansion of its capacity to provide culturally competent services in the MHSA-funded programs described in the CSS Plan. The following objectives include specific strategies and interventions to address access to care disparities countywide:

- Conduct outreach to engage and increase access to care for Latinos and Asian/Pacific Islanders, African Americans, and Native Americans in the mental health system.
- Increase penetration and rates of client retention for underserved and unserved clients in age groups and racial/ethnic groups and for females.
- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs.
- Provide culturally competent mental health services in all MHSA programs by educating and training providers on evidence-based and promising clinical practices, interventions and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence.

- Include training on working with interpreters, the deaf and hard of hearing, victims of trauma, and gender and sexual orientations in cultural competence training.
- Require enhancement of the bilingual and bicultural capacity in all programs by recruiting, hiring, retaining and retraining culturally competent staff.
- Address disparities in services for females in all age groups by requiring MHSA programs to ensure females are assessed for mental illness.
- Increase access to services for all ethnic/racial groups and females by implementing the MHSA program to provide more mental services in community clinics.
- Establish relationships with tribal communities for as many of the 17 Native American tribes as possible who have reservations in San Diego County.
- Implement a Breaking the Barriers program, designed to evaluate how to address stigma and increase access for selected underserved communities.

WET Plan Strategies/Actions/Objectives/Timelines

- Address shortages in bilingual staff – Spanish, Vietnamese, Arabic, Tagalog, Russian, Cambodian, ASL, Lao, Somali, and Swahili.
- Implement trainings/educational opportunities to build staff to fill unique qualifications for hard to fill jobs and for clinical supervision.
- Create incentives to encourage nurses, child psychiatrists, etc. to enter public mental health employment and take hard-to-fill positions.
- Increase the numbers of Latino and African American staff.
- Create positions and a career ladder for mental health consumers and/or family members.

PEI Strategies /Actions/Objectives/Timelines

The PEI Work Plan identified the following strategies towards reducing disparities.

- Provide education and outreach campaigns to reduce stigma and discrimination and to aid in suicide prevention for all age groups, race/ethnicities, persons with co-occurring substance abuse disorders, and caregivers.
- Assist in maintaining a safe home and a community safety net for children and in reducing the effects of trauma exposure (including gang experience).
- Promote healthy, effective parenting styles, connecting children with necessary health and other related service, to prevent re-traumatization of children and families already exposed to domestic and/or community violence.
- Increase Native American community involvement and education through services designed and delivered by Native American community members.
- Strengthen the skills of parents, staff, and educators to promote the development, growth, health, and social competence of young children and help reduce their behavioral/emotional problems.
- Reduce the potential negative outcomes associated with mental health issues in the early stages of mental illness.
- Increase access to care for older adults from minority populations.

- Educate caregivers and primary care service providers to increase awareness and understanding of the older adult concerns and create a wellness focus.
- Support caregivers of clients with Alzheimer's, to reduce incidence of caregiver mental health problems.
- Provide outreach and outreach services to the Veterans community to improve their knowledge of and access to mental health services.
- Provide prevention services for clients in rural community clinics to help them address behavioral health issues, addiction, and severe mental illness at an early stage.
- Support persons being treated for substance abuse in dealing with mental health issues through providing integrated services.

B. List the strategies/actions/timelines identified for each targeted area as noted in Criterion 2 in the following sections:

II. Medi-Cal population → *combined for San Diego*
III. 200% Poverty combined for SDCMHS →

The SDCMHS has historically conducted its planning for the combined populations of Medi-Cal and 200% Poverty, as explained in Criterion 1. Prior to receiving MHSA funding, the SDCMHS already had adopted a number of strategies to increase access to care and reduce disparities for ethnic, racial, and cultural groups. Changes in services over the years have occurred in both the Adult System of Care and the Children's System of Care.

As a result of the planning process which occurred in the preparation of the 2003-04 Cultural Competence Plan, SDCMHS, in light of a rapidly expanding County population, began to work toward increasing cultural competence among its County and contractors by encouraging and incrementally requiring programs to become more self-evaluative about their cultural competence. The following Culturally Competent Clinical Practice Standards were adopted for the SDCMHS:

1) Providers engage in a culturally competent community needs assessment.

2) Providers engage in community outreach to diverse communities based on the needs assessment.

3) Providers create an environment that is welcoming to diverse communities.

4) Staffing at all levels - clinical, clerical, and administrative, shall be representative of the community served.

5) There is linguistic capacity and proficiency to communicate effectively with the population served.

6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.

7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders; b) culture-bound syndromes; c) cultural explanations of illness; d) help seeking behaviors, including faith-based, in diverse populations; and e) appreciation for traditional ethnic and cultural healing practices.

9) Cultural factors are integrated into the clinical interview and assessment.

10) Staff shall take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic, and life experiences context of the client.

11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.

12) Psychiatrists consider the role of cultural factors (ethnopsychopharmacology) in providing medication services.

13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.

14) Staff actively seek out educational, consultative and multicultural experiences, including a minimum of four hours of cultural competence training annually.

These standards are contained in the Organization Provider Operations Handbook-- a part of all service provider contracts. The Cultural Competence Chapter of the Handbook was expanded. The requirement that consumers be given an initial choice of clinician, with the right to choose cultural specific providers, was included, as was the need to provide services in the clients preferred language. Key points of contact for services in threshold languages were also established.

The Handbook also encouraged providers to assess local community needs, develop and implement a Cultural Competence Plan for each provider site, and to develop a process to assess staff cultural competence. In conjunction with the Cultural Competence Resource Team, the SDCMHS researched, evaluated, and piloted tools for provider cultural competence self evaluation, ultimately deciding the Culturally Competent Program Self Assessment (CC-PAS) would be used systemwide. The tool has been distributed to providers with instructions on its usage. The use of the CC-PAS will be a requirement in FY 10-11 in all new service contracts and re-procurements.

The SDCMHS, aware of its problems in reaching the adult/older adult Latino population, structured its Latino Access to Care Performance Improvement Project around outreach effort to the Latino Medi-Cal beneficiary population. A sampling of mono-lingual Spanish speaking or Spanish speaking-preferred Medi-Cal beneficiaries found that 48% did not know they had the right to mental health services. New, improved informative brochures and other informing materials in Spanish were created and distributed to new and current Latino beneficiaries. An electronic and print media campaign was under-taken. Staff at the County's Family Resource Centers, human service organizations, primary care clinics/physicians were educated about mental health services available through the SDCMHS, admission criteria, and how to make referrals. The result was a 14% increase in the number of new Latino Medi-Cal beneficiaries and a 7% increase in the number who knew of SDCMHS.

SDCMHS evaluated its systemwide progress toward addressing cultural disparities in treatment in its Disparities Report (mentioned in previous sections of this Plan and contained in the Appendix, Criterion 3, pp. 3.II.A.1-5) and noted that comparatively little progress had been made between FY 2001-02 and FY 2006-07. The Report outlined disparities by age group and ethnicity which needed to be addressed. The data served as a guide for planning the effective usage of MHSA CSS, PEI and WET funding.

In FY 09-10, to help outpatient and case management programs know if they were serving their contract targeted population, all adult outpatient and case management programs were given an individual program profile, based on client services provided and demographic information. Providers were able to see the breakdown of their populations served by age, gender, race/ethnicity and diagnosis. In FY 2010-11, the SDCMHS will begin to look at these factors as a guide to a program's ability to meet its target population.

To increase access to care and decrease disparities in services by ethnicity in the Children's Mental Health Services, school based services were begun in 1998, starting with only 7 schools. The expansion of EPSDT funding in 2002 allowed for a significant expansion of school-based mental health services. Using MHSA funding for further expansion, the program has grown to 42 school systems and more than 350 school-based sites in FY 2009. This expansion has resulted in bringing mental health services into local communities throughout the county, each one with its own ethnic and cultural mix. The penetration rate for Latino children increased from 3% in FY 01-02 to 5% in FY 06-07. It is expected that the update to the Disparities Report (coming in 2011) will show a continued increase in the penetration rate, as the results of MHSA school-based expansion become evident.

Next Steps

The SDCMHS has created the Quality Improvement Plan below as a means of maintaining the focus on cultural competency, improving access to care, and decreasing disparities for ethnic/racial and cultural populations.

Quality Improvement Plan
Strategies for Addressing Disparities
Updated for FY 10-11

The Quality Improvement Plan for addressing cultural disparities in San Diego County involves

1) Evaluating root causes of disparities in San Diego
    a. Work with CCRT to identify methods for evaluating the root causes of disparities in San Diego- Should be added to agenda for CCRT
        i. Conduct a study through HSRC/CASRC to identify root causes of disparities with clients and family members- June 2011
        ii. Conduct research of other studies on disparities- HSRC and CASRC will be asked to find studies- Dec 2010
        iii. Identify community groups that represent age/racial/ethnic/cultural diversity and do focus groups with them to identify root cause of disparities- June 2011
2) Assessing effectiveness of current strategies and interventions- as part of Cultural Competence Plan when State gives counties guidelines- on hold
    a. Determine what current strategies and interventions are being used (identify targeted programs, training, language assistance)- establish date for delivery to CCRT
    b. Analyze effectiveness
        i. Utilize client satisfaction surveys to identify strengths and weaknesses by program
        ii. Look at other outcomes measures- Ensure that IMR, RMQ and PEI are evaluated for age/racial/ethnic/cultural populations
3) Implementing stigma and discrimination educational campaign- MHSA
    a. Stigma and discrimination campaign to kick off in FY - Sept 2010
    b. Work with MHSA staff to ensure that age/racial/ethnic considerations are taken into consideration- completed
4) Evaluating cultural sensitivity of providers and services-
    a. Facilitate the implementation of the CMCBS to evaluate staff-- Need to identify who will do this- need to add this to RFPs and contract amendments

b. Implement the Culturally Competent Program Annual Self-Evaluation (CC-PAS) for new and reprocured programs
    i. Incorporate into Provider Handbook- QI- completed – distributed in Nov 2009
    ii. need to add this to RFPs and contract amendments
    iii. Begin tracking completion- new date?

5) Improving quality of care by working with ethnically diverse groups
    a. Complete and distribute CC Handbook- QI- Dec 2010
    b. Identify Culturally Competent EBP, best practices, proven practices- Policy and Practice Committee- will identify 2 new practices by – Dec 2011
    c. Work with Clinical Standards committee to ensure interventions are culturally appropriate- Members of CCRT who are also on Clinical Standards on-going
    d. Study results of outcome measure based on age/racial/ethnic groups- Performance Outcomes Completed Disparity report for 5 year comparison 2001-2002 compared to 2006-2007, will repeat for 09-10 (Data available for comparisons in Jan 2011. Report will be available in spring)
    e. Identify community groups that represent age/racial/ethnic/cultural diversity and do focus groups with them to identify areas for improvement- not started yet

IV. *MHSA/CSS population -- Objectives/Actions/Timelines*

SDCMHS started 40 programs to continue its work in addressing disparities. Included below is an excerpt of a chart prepared for this report which details each program, listing its goal, target population, services offered and the date services began.

CSS PROGRAM SUMMARY

Old CSS Plan	Program	Program Description	Program Goal	Target Population	Services Offered	Services Began:
ALL-1	Services for Deaf & Hard of Hearing	A specialized outpatient service for underserved/unserved individuals of all ages who are deaf or hard of hearing, including those who may have a co-occurring substance use disorder.	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning.	• Underserved/unserved • Seriously Emotional Disturbed and Seriously Mentally Ill individuals of all ages • Deaf or hard of hearing • Targets individuals with co-occurring substance use disorder	• Assessment • Crisis Intervention • Individual Therapy • Collateral Contact • Group Therapy Sessions	01/10/07
			Countywide specialized outpatient mental health services to unfunded clients who are victims of trauma and [illegible]ture.	• Uninsured, unserved SED/SMI individuals who are victims of trauma and torture • Children (age 0-17) • Transition Age Youth-TAY (age 18-24) • Adults (age 18-59) • Older Adults (age 60 years and over)	• Mental health assessment • Dual diagnosis services • Individual and group therapy • Case management and referrals	12/18/06

See complete Table in Appendix, Criterion 3, pp. 3.III.B.IV.1-19

Below are brief descriptions of all CSS Plans.

CSS Plan: ALL-OE All Ages Outreach and Engagement

ALL-1 Service for Deaf and Hard of Hearing - Outpatient services for deaf or hard of hearing, including those who may have a co-occurring substance use disorder.

ALL-2 Services for Victims of Trauma and Torture - Specialized outpatient mental health services to unfunded clients who are victims of trauma and torture.

ALL-6: CY 4.1, A-7 & OA-3 Mental Health & Primary Care Services Integration - Mental health assessment and treatment services at community health clinic settings across San Diego County.

CSS Plan: ALL-SD All Ages System Development

ALL-4 Interpreter Services – Interpreter Services expansion.

ALL-5 Psychiatric Emergency Response Services – Expansion of services that pairs law enforcement officers with psychiatric emergency clinicians.

ALL-7: A-9 Chaldean Outpatient Services – Outpatient mental health services.

CSS Plan: CY-FSP Children and Youth Full Service Partnerships

CY-3 Cultural Language Specific Outpatient - Full Service Partnership mental health services to Latino and Asian/Pacific Islander children, youth and their families.

CY-5.3 Homeless/Runaway Mental and Behavioral Health Services – FSP for homeless and runaway children and youth.

CY-7 Wraparound Services - Wraparound mental health services to clients and their families currently in Child Welfare Services custody and residential placement.

CY-10 Child/Youth Case Management - Enhance outpatient services to children, youth, and families in six outpatient clinics.

CSS Plan: CY-OE Children and Youth Outreach and Engagement

CY-1 School Based Mental Health Services - Expands Medi-Cal funded programs to include unserved clients (those with no access to services).

CY-5.2 Mobile Adolescent Services Team (MAST) - Mental health assessment and treatment services located at Juvenile Court and Community School (JCCS).

CSS Plan: CY-SD Children and Youth System Development

CY-2.1 Family and Youth Information/Education Program - Conduct forums regarding the de- stigmatization of mental illness and the use of psychotropic medication.

CY-2.2 Family/Youth Peer Support Services - Provide support and linkage to services and community resources to children/youth and their families.

CY-4.2: ALL-3 Mobile Psychiatric Emergency Response & North County Walk-In Assessment Clinic - Provide mobile crisis mental health response in conjunction with a Walk-In Assessment Clinic for the North County.

CY-5.1 Medication Support for Wards and Dependents - Provide short term stabilization with psychotropic medication and linkage for on-going treatment.

CY-6 Early Childhood Mental Health Services/ChildNet SED - Uses the “Incredible Years” evidence based practice model and a family approach.

CY-8 Placement Stabilization Services - Provide mental health services to clients and their families to stabilize and maintain children and youth in home-like settings.

CY-9 Juvenile Mental Health Re-entry Program - Provide mental health screening of all youth detained in the Kearny Mesa Juvenile Detention Facility.

CSS Plan: TAOA-FSP Transitional Age Youth, Adult and Older Adult Full Service Partnerships

A-1 Homeless Integrated Services and Supported Housing – Assertive Community Treatment, Full Service Partnership.

A-2 Justice Integrated Services and Supported Housing - Assertive Community Treatment (ACT), Full Service Partnership (FSP).

TAY-1 Integrated Services and Supported Housing - Assertive Community Treatment (ACT), Full Service Partnership (FSP).

TA-1 Intensive Case Management - Short-term intensive case management.

TA-2: Formerly TAY-3 Dual Diagnosis Residential Treatment Program – Comprehensive, 24/7, residential dual diagnosis. Full Service Partnership Services.

OA-1 Higher Utilizer Comprehensive Integrated Services and Supported Housing – An Assertive Community Treatment (ACT) approach and Full Service Partnership services to Older Adults who have a SMI.

TAOA-3 Housing Trust Fund - Increase permanent supportive housing opportunities for clients in the five Full Service Partnership (FSP) Integrated Homeless Programs.

TAOA-5 Mental Health Court Calendar Diversion and Supported Housing - Comprehensive, integrated culturally competent mental health services for individuals with a serious mental illness who have been found guilty of a non-violent crime and are awaiting sentencing.

CSS Plan: TAOA-SD Transitional Age Youth, Adult and Older Adult System Development

A-3 Client Operated Peer Support Services - Client-driven and client-operated countywide support services in a variety of settings.

A-4 Family Education Services - Education about mental illness, stigma reduction and resources.

A-5 Clubhouse Enhancement and Expansion for Employment Services - Expanded capacity for social and community rehabilitation activities and employment services.

A-6 Supported Employment Services - For Transition Age Youth, Adults and Older Adults with SMI.

A-10 Patient Advocacy Services for Board and Care Facilities - Provide Patient Advocacy Services for mental health clients residing in Board and Care facilities throughout San Diego County.

TAY-2 Clubhouse and Peer Support Services - A member-run Clubhouse for TAY who have a SMI.

TAY-4 Enhanced Outpatient Mental Health Services for TAY - Mental health services for Transition Age Youth (TAY).

OA-2 Mobile Outreach at Home and in the Community - An Assertive Community Treatment (ACT) approach and Full Service Partnership services to Older Adults who have a SMI. Countywide 24/7 mobile outreach services.

OA-4 Strength-based Care Management Services - Care Management and Recovery & Rehabilitation services following the Strength-based Care Management model

AOA-1: A-8 Enhanced Outpatient Mental Health Services - Enhanced Outpatient Mental Health Services For Adults.

TAOA-1 SSI Advocacy/Legal Aid Services - Review and submittal of SSI applications to SSA that Clubhouse SSI Advocates have completed.

TAOA-2 North County Walk-In Assessment Center - Urgent mental health services to Adults and Older Adults in the North County.

TAOA-4 Peer Telephone Support Expansion - Phone support for any consumer of mental health services.

Administrative Services

AS-1 Data Analysis & Performance Monitoring – Adult and Older Adult mental health services.

AS-2 CMHS Data Service Expansion - Tracks client and system outcome measures, evaluate programs and provide service utilization data.

AS-3 Administrative Services Organization Expansion - Provide crisis services and referral. Facilitate access through the Fee for Service Provider network.

AS-4 Housing/Capital Facilities Technical Consultant - Technical expertise on housing development.

AS-6 Consultant/Community Education Contractor - Develop a Behavioral Health Training Curriculum and a System Wide Education and Training Plan.

AS-7 Child and Youth Consumer/Family Liaison - Coordinate client and family input in the areas of policy, practice, and program development of Children's Mental Health Services.

AS-7 Adult Consumer/Family Liaison - Coordinate client and family input in the areas of policy, practice, and program development of Adult Mental Health Services.

OT-1 System-wide Community Education Training and Technical Enhancements - Computers, telemedicine equipment and a training room to enhance clinical services.

OT-1a System-wide Community Education Training and Technical Enhancements – additional funding for telemedicine equipment.

OT-2.2 Breaking Barriers Initiative – Collaboration with stakeholder groups in selected pilot communities to challenge stigma associated with severe mental illness.

V. PEI priority populations (s) selected by the county, from the six PEI priority populations—Objectives/Actions/Timelines

SDCMHS started 30 programs to provide Prevention and Early Intervention (PEI) services to hard-to-reach populations to reduce stigma associated with mental illness, make people aware of mental health resources in their communities, and connect underserved and unserved populations with resources at an early stage of their mental illness. Included below is an excerpt of a chart prepared for this report which details each program, listing its goal, target population, services offered and the date services began.

PEI Plan	Program	Program Description	Program Goal	Target Population	Services Offered	Start Date
PS-01	& Secondary Prevention – Public ach, Education and Support Lines	County-wide public media campaign geared towards suicide prevention and stigma and discrimination reduction via education and outreach. Campaign also raises awareness of new PEI programs. In addition, this program provides County-wide, nfidential, peer- support phone adults,	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increase awareness of available MHSA PEI services. Provide support and increase knowledge of mental illness and related issues. Reduce stigma and harmful outcomes.	• County-wide • Individuals with mental illness • Families of individuals with mental illness • General public • County-wide • Youth • Family members	• Public media campaign to education and promote mental health concerns • Print, radio, and TV ads • Printed materials • Non-crisis, peer phone support and referrals • Mental health education • Afternoon and evening services, 5 days a week	4-1-09
		lish a community ensure the ing of	• Children, 0 to 17 years • Families • Located in the outh Region of ego	• Safety and risk assessment for children conducted in the home • Caregiver stress assessment • Linkage and referral to appropriate services	5-1-09

See complete Table in Appendix, Criterion 3, pp. 3.III.B.V.1-8

PEI PROGRAMS

PS-01 Primary and Secondary Prevention – Public Outreach, Education and Support Lines: County-wide public media campaign geared towards suicide prevention and stigma and discrimination reduction via education and outreach

DV-01 Families as Partners: Services and engagement with community resources and supports for families in the South Region in order to assist in maintaining a safe home for children, establish a community safety net, and reducing the effects of trauma exposure

DV-02 South Region Trauma Exposed Services: Services and referrals to prevent re-traumatization of children and families who experience trauma related to exposure to domestic and/or community violence

DV-03 Alliance for Community Empowerment: Community violence response team and services to siblings of identified gang members in an effort to increase community resiliency and combat the negative effects of violence. Increase the resiliency of individuals, families, and the community to address and reduce the impact of community violence and trauma.

NA-01 Collaborative Native American Initiative: Urban Youth Center, elder services/navigator program, suicide prevention program, and outreach and prevention program for the Native American community

EC-01 Positive Parenting Program (Triple P): Three levels of the Triple P parenting program to educate parents with children exhibiting behavioral/emotional problems in Head Start and Early Head Start Centers. Strengthen the skills of parents, staff, and educators to promote the development, growth, health, and social competence of young children

SA-01 School-Based Program: Family-focused approach that engages families in their child's school success. School-based interventions with families are coordinated and designed to improve child/parent social and emotional skills. Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children

SA-02 Suicide Prevention Education Awareness and Knowledge (SPEAK): Suicide prevention program to serve students through education, outreach, screening, and referrals in schools. Program includes education to school staff and families

FB-01 Kick Start: Services for individuals at-risk for developing or experiencing a first break of serious mental illness that includes outreach, education, and intervention.

OA-01 Elder Multicultural Access and Support Services (EMASS): Peer-based outreach and engagement to older adults to support prevention of mental illness and increase access to care. Reduce ethnic disparities in service access with a focus on Hispanic, African refugee, African American, and Asian/Pacific Islanders.

OA-02 Positive Solutions Program: Outreach, and prevention and early intervention services for older adults who receive meals delivered through the Aging and Independence Services program by using Program to Encourage Active and Rewarding Lives (PEARLS) model.

OA-03 Life Long Learning Aging and Wellness: Education program targeting older adults, families, caregivers, and providers on issues relevant to the older adult community. Increase awareness and understanding of older adult concerns with a wellness focus. Reduce stigma and incidence of suicide and mental health issues for older adults.

OA-04 REACHing Out: Intervention to caregivers of Alzheimer's patients to prevent/decrease symptoms of depression, isolation, and burden of care through bilingual/bicultural Peer Counselors, targeted toward Hispanic caregivers in South Bay Region.

OA-05 Salud: Integrated treatment of depression and diabetes in primary care settings for Hispanic older adults by assigning one care provider for both health concerns. Integrate treatment of co-occurring health and mental health issues.

VF-01 Courage to Call Program: Confidential, peer-staffed outreach, education, and training services to the Veteran community and its service providers.

RC-01 Rural Integrated Behavioral Health and Primary Care Services: Assessment and short-term interventions in rural community clinics for individuals who may be at risk for or in the early stages of mental illness.

CO-01 Co-occurring Disorders – Bridge to Recovery: Early intervention services to individuals presenting at crisis emergency facilities who have high substance use issues and early mental health concerns.

CO-02 Co-occurring Disorders – Screening by Community-Based ADS Providers: Addition of mental health counselors to residential and outpatient Alcohol and Drug Services programs to identify and screen clients with or exhibiting mental health concerns. Support integrated treatment of co-occurring issues for those enrolled in substance abuse treatment

WET PLAN--Objectives/Actions/Timelines

SDCMHS started 9 additional programs to address disparities in the workforce, so that the County can more effectively provide services for ethnic/racial and cultural populations. These programs are targeted at expanding the workforce and making skills development training available to existing staff. Included below is a chart prepared for this report which details each program, listing its goal, target population, services offered and the date services began.

WET Program	Program Description	Program Goal	Target Population	Contract Award
#1 Workforce Staffing Support WET Coordination and Implementation	Provide a structure that supports building & maintaining a culturally competent public mental health workforce	To have a culturally competent workforce that includes clients and family members capable of offering client and family-driven wellness, recovery, and resilience-oriented services within an integrated service experience.	County of San Diego Mental Health Staff	County of San Diego Mental Health Administration WET Consultant- Started 3/15/10 Linda Tarke, LCSW, Independent Consultant
#2 Training and Technical Assistance Specialized Training Modules	Develop training modules that support the core competencies for the public mental health workforce	To increase the number and diversity of trainings offered to San Diego County's public mental health workforce	San Diego County public mental health workforce	0-5 Certification Program awarded to San Diego State University Research Foundation and started on 7/1/10 BHETA-provide behavioral health training to County and Contractor staff
#3 Mental Health Career Pathway Programs Public Mental Health Academy	A collaborative, community-based educational academy that lead to certification, skill development & employment in the public mental health workforce.	To reduce barriers to employment and create opportunities for individuals, including consumer and family members to become part of San Diego County's public mental health workforce	Individuals that are ethnically and linguistically diverse, including consumer and family members	Full award recommendation was made to San Diego Community Colleges- City Campus and partial award recommendation was made to Alliant International University
#3 Mental Health Career Pathway Programs Geriatric Mental Health Certificate Training	A partnership with a local academic institution to implement a Geriatric Mental Health Certificate	To graduate a cadre of Geriatric Mental Health Specialists that will lead the way in quality and age appropriate care for older adults	100 existing mental health services and aging network staff delivering mental health services to the aging	Academy of Excellence-BHETA- started 7/1/10

WET Program	Program Description	Program Goal	Target Population	Contract Award
	Training Program.	with mental illness in San Diego County.	population	
#3 Mental Health Career Pathway Programs Consumer & Family Pathway/Academy	To encompass a variety of mental health career trails that would provide practical, specialized training for individuals and family members with lived mental health experience.	To assist individuals who have lived through experiences in the system to: 1) enter into the public mental health workforce, 2) transition into more advanced positions within the public mental health workforce, and/or 3) become (or assist in re-entry as) a credentialed practitioner.	Individuals and family members with lived mental health experience	NAMI RICA Family Youth Roundtable Started in 2008
#4 Mental Health Career Pathway Programs School-Based Pathways/Academy	To implement a mental health component/track to existing established Health Care Pathways programs and to provide mental health internship opportunities to high school students.	To promote mental health careers to high school and middle school students	High School and Middle School Students	Health Sciences High & Middle College-Start date is 9/1/10
#5 Mental Health Career Pathway Programs Nursing Partnership for Public Mental Health Professions	County of San Diego will explore partnering with local higher education institutions in a variety of nursing pathways/areas	To expand the capacity for developing additional public mental health professionals in nursing occupations that are most needed	Linguistically, culturally and economically diverse students in Nursing and clinical university programs	California State University San Marcos Start date is 9/1/10
#6 Residency, Internship Programs Community Psychiatry Fellowship	Partnership with a medical school to fund a position(s) to increase family medicine/psychiatry fellows with a community psychiatry specialization	To increase the number of community psychiatrists in the public mental health system	Psychiatry Residents	Currently in contract negotiations

WET Program	Program Description	Program Goal	Target Population	Contract Award
#7 Residency, Internship Programs Child Psychiatry Fellowship	Partnership with a medical school to fund a position with the intent of increasing family medicine/ psychiatry fellows with a child psychiatry specialization.	To increase the number of child psychiatrists in the public mental health system who are trained in the multicultural issues of a diverse population & value including consumers & family members in the service delivery system.	Child Psychiatry Residents	Currently in contract negotiations
#8 Residency, Internship Programs LCSW/MFT Residency/Intern	Develop a partnership with established LCSW and MFT training programs to fund residency/internship slots to offer students compensation in exchange for a commitment to practice in San Diego County's public mental health workforce.	To increase the presence of licensed individuals in San Diego County	Culturally diverse (e.g. Latino, African –American, Vietnamese, Cambodian, Lao & Samoan, Chaldean, Somali) LCSW/MFT Residents and Interns	LEAD: San Diego State University (MFT), Alliant International University (MFT) and San Ysidro Health Center (LCSW) Start date is 9/1/10
#9 Financial Incentive Programs Targeted Financial Incentives to Recruit and Retain Licensable and Cultural, Linguistically and/or Ethnically Diverse Public Mental Health Staff	Prepare candidates to work with specifically targeted populations such as children, youth, transition age youth, adults, and older adults.	To aid in the recruitment & retention of license eligible and culturally, linguistically, and/or ethnically divers public mental health staff in both the County and contracting CBOs.	Culturally diverse (e.g. Latino, African –American, Vietnamese, Cambodian, Lao & Samoan, Chaldean, Somali, LGBT, foster care experience) students and faculty	Recipients of larger stipends will be contractually obligated to work for Mental Health Services of contracting CBOs after completing studies for a period of time equal to the period on which they received support. Student and faculty stipends were awarded to the School-Based Pathways, Public Mental Health Academy and the LCSW/MFT Intern Programs.

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

IV. Additional strategies/objectives/actions/timelines and lessons learned

The county shall include the following in the CCPR:

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI.
Note: *New strategies must be related to the analysis completed in Criterion 2.*

The SDCMHS, continuing its effort to remediate disparities in treatment, has developed several new strategies:

- Individual Program Assessments—In FY 09-10, all adult outpatient and case management programs have been given a program profile, describing their clients by age, diagnosis, gender, race/ethnicity, preferred language, substance use, service use, and insurance. In FY 10-11, each program's performance will be compared to program targets geared to addressing disparities to help determine how well it is serving the populations that it has been contracted to serve.
- Peer Support Services in the Hospitals—As noted in our Disparities Report and Databook, there are several minority populations who receive services in hospitals or jail without being successfully linked to outpatient services. By providing peer support in hospitals, the shared experience factor may give patients and their families the knowledge and additional motivation to connect with outpatient services.
- The KidSTART program was developed as a response to the need of integrated services for foster children ages 0-5. This program was developed in collaboration with the First 5 Commission and Child Welfare Services. KidSTART provides a focused, comprehensive system to identify, assess and treat children with developmental delays, behavioral and/or mental health issues at the earliest age possible, when that treatment can be most effective and cost-efficient. The core principles of KidSTART service delivery are: developmental knowledge, relationship/attachment focus, family support, links to existing children's services, responsiveness to community and culture and trackable outcomes.
- The County of San Diego in order to better prepare youth placed in San Diego Center for children attending intensive day treatment for their transition into a less restrictive, community based or family care settings integrated the Transition to Independence Process Model (T.I.P.) living skills program into the day treatment program structure. Clients in this program are referred from Child Welfare Services, Juvenile Probation and AB2726. Each client receives an individualized, strength-based, culturally competent, client and family driven service plan. Each plan identifies client baseline functioning, strengths and resilience, cultural norms, co-occurring disorders and domestic violence issues as well as the goals to be achieved. The program provides clients with social skills and independent living skills training, education appropriate to adolescent issues/lifestyle concerns (i.e. sex education, drug education), opportunities to be engaged in the community in age-appropriate activities, and opportunities for vocational/career counseling and community employment.

A1. Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

The SDCMHS has been trying various strategies to try to increase access to appropriate levels of care for ethnic/racial and cultural minorities and to decrease disparities in services. Among the most successful efforts has been the spread of the school based programs throughout the County. Starting from a presence in only 7 schools about 10 years ago, the program has grown to be in more than 350 schools through EPSDT and MHSA funding. All 42 school districts in the County are participating in the program. The use of school sites, as non-threatening locations, has removed some of the stigma from seeking services. The availability of bilingual staff and interpreter services has contributed to the successful engagement of some families who otherwise would not have sought assistance. Of course, the cooperation of the school systems and teachers has been an integral part of this successful outreach, facilitating referrals and assisting in community treatment. The penetration rate for Hispanic children has shown an increase from 3% in FY 01-02 to 5% in FY 06-07, with additional increases expected for the years when MHSA was fully implemented. (Penetration rates will be updated in 2011.)

Two programs funded through MHSA CSS target specific populations: The Chaldean Program funded through MHSA CSS began in 2008 because of the large number of Iraqi refugees located in the east region and their need for mental health services; and Survivors of Torture whose goal is to improve access and increase the number of culture-specific services to persons who have been victims of trauma and torture.

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

(Criterion 3, Sections I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

The county shall include the following in the CCPR:

A. List the strategies/objectives/actions/timelines provided in Sections III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.).

Please see the charts above used for Section III for CSS on pages 10-12, PEI on pages 13-14, and WET on pages 15-17 which contains strategies and actions, as well as, including a start date or estimated start date for each of the programs. All CSS programs are underway and all PEI programs have recently become operational. WET Programs are in the procurement process or just beginning in Fall, 2010 and beyond.

B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

Note: *County shall be ready in 2011 to capture and establish current baseline data to be used for ongoing quality improvement and qualitative analysis of the county's efforts to reduce identified disparities. Baseline data information and updates of the county's ongoing progression in the reduction of mental health disparities will be required in 2011 and in subsequent CCPR Annual Updates.*

Additionally, in subsequent CCPR Annual Updates, counties will share what has been working well and lessons learned though the process of the county's planning and monitoring of identified strategies, objectives, actions, and timelines to reduce mental health disparities.

San Diego undertook a review of the tools and reports it was using to monitor program and client outcomes between 2008 and 2010. The SDCMHS goal was to be better able to measure the success of efforts to increase access to appropriate-level services for the underserved and unserved, as well as to build the recovery orientation of its mental health system. The tools which are being used include:

- To help establish a baseline for measurement, the Disparities Report -- Progress Toward Reducing Disparities FY 2001-02 to FY 2006-07 (see Appendix, Criterion 2, pp. 2.III.B.16-81) gives a picture of the disparities which existed in the system prior to the start of MHSA funded programs.
- In FY 2008-09, QI developed a Program Databook Report on approximately 200 individual outpatient and case management programs containing information on the age, gender, diagnosis, and race/ethnicity, preferred language, substance use, and insurance status of clients served, as well as the services provided. This report was given to the Contracting Officers Technical Representatives who were able to use it to track the populations actually being served and the services they received to include in discussions with individual program managers on program functioning.
- In FY 2009-10, a refinement of the Program Databook Report is being created to evaluate how well individual programs meet their contract targeted populations. This report will give the SDCMHS another tool to measure how well diverse cultural groups are being served. The first version of this report is expected in October, 2010. This report will be used by Mental Health Administration as a factor in weighing the effectiveness of a program's performance, and, of course, will be shared with programs management.
- SDCMHS QI Unit is planning an update of the Progress Toward Reducing Disparities Report when final FY 2009-10 data is available and will measure the effects of MHSA targeted spending on reducing services disparities by age, gender, and race/ethnicity. This report is projected for a Spring 2011 completion and is expected to be updated every three years thereafter.
- SDCMHS is planning to use 2010 Census data to provide a baseline about San Diego's current population, age, gender, ethnic/racial makeup, and income level. New prevalence data for SDCMHS will also be developed incorporating the Census data and from that an updated Gap analysis may be constructed.
- In order to understand, from the clients' perspective, their progress toward recovery, the SDCMHS has implemented the use of the Recovery Markers Questionnaire (RMQ) for

- The SDCMHS, in conjunction with its UCSD Research Centers, provider, and client representatives selected the Recovery Self-Assessment (RSA) as a short effective tool to measure adult client, staff, and program management perceptions of provider practices thought to be indicative of a recovery supportive environment. The client tool was first administered as an add-on to the State Survey in FY 2009-10 and reflects clients' perceptions of five recovery supporting areas at their program: Life goals, involvement, diversity of treatment options, choice, and individually tailored services. (See RSA in the Appendix, Criterion 3, pp. 3.V.B.1-14.) The RSA will be used to track changes in client perceptions about the cultural competence of their programs, among other things.

- The staff version of the RSA was piloted in Spring 2010 for Adult Outpatient and Case Management Programs. This tool also includes questions rating the cultural competence of the individual programs and was completed by a sampling of clinicians. SDCMHS administrative staff also took the RSA to rate the cultural competence of the system. A discussion of the comparative scores will be found in Criterion 8, Section IV. B.

- SDCMHS will continue to monitor adult/older adult client satisfaction with services through the use of the MHSIP/CQL State developed survey tool. The County feels that the survey is an important way to hear the client voice on the program level. Many of the County's providers have a requirement in their contract to participate in this survey. Survey tools have been provided by the State in the threshold languages of Spanish, Vietnamese, and Tagalog, and providers have also requested copies in some of the various other languages provided by the State. Client satisfaction is compared between non-English speaker and English speakers. Results, historically, have shown a high level of satisfaction in all areas except Treatment Planning. Results for non-English speakers have consistently been higher than English speakers, leading the SDCMHS to start conducting focus groups to get picture of client issues among non-English speakers. The County is considering translating the Client Satisfaction tool into Arabic in FY 2010-11.

- In an effort to see any trends which might reflect disparities, the SDCMHS continues to monitor client transfers on the Monthly Status Reports received from each outpatient program. Additionally serious incidents and grievances and appeals are monitored for service disparities by race/ethnicity, culture.

- SDCMHS monitors children and youth outcomes through the Child and Adolescent Measurement System (CAMS) which measures changes in client assessments by youth and parent/caregivers as indications of a child/youth’s progress in treatment. The clinician’s observations of progress are measured with the Children’s Functional Assessment Rating Scale (C-FARS). Scores for both assessments are aggregated, evaluated, and reported on each individual program.

- SDCMHS will also continue to monitor youth and parent satisfaction with services through the use of the Youth Satisfaction Survey (YSS) to hear the client voice on the programmatic level.

- Children's Mental Health works in partnership with the Children's Mental Health System of Care Council which provides community oversight, feedback and advice of the services provided and needed services

- Children's Mental Health has a contract with the Regents of the University of California San Diego (UCSD) to track Children's Mental Health Services client and system outcome measures, evaluate programs and provide service utilization data. Reports provided by the contractor assist in making the appropriate decisions in regards to the reduction or elimination of disparities

- Additionally, Children's Mental Health:
    - Reviews Monthly Status Reports (MSRs) from providers as a monitor tool for data and outcomes
    - Reconciles MSRs to Units of Services reports and Admissions, Discharges and Census (ADC) reports
    - Updates MSRs templates annually, or more often if necessary
    - Hosts monthly meetings with regional program managers ensure that all programs receive timely System of Care updates
    - Monitors Wait List Data monthly
    - Reviews the AB 2726 Outpatient Referrals report
    - Reviews the AB 2726 Indigent Clients on Medications report
    - Reviews Provider Monitor report monthly
    - Conducts programs' site visits annually, or more often if necessary
    - Reviews the Cultural Competence Staffing report twice a year
    - Reviews the Cultural Competence Training report twice a year
    - Reviews the EPSDT reconciliation report annually
    - Reviews and analyses Costs Reports quarterly
    - Conducts a semi-annual and annual Cost Report analysis
    - Updates contracts' Statements of Work as necessary
    - Updates contracts' monitoring plans annually

Next Steps

- SDCMHS is in the process of developing information on program costs as another way to add to the toolbox in comparing effectiveness of various programs in meeting cultural diversity needs. To date, we have not found a satisfactory methodology to develop these costs.

C. Identify county technical assistance needs.

SDCMHS would like technical assistance on:

- The methodology for developing accurate program costs and program savings information.
- The development of a quality measure to be used across the State to allow a broader comparison of performance.

CRITERION 4

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

Client/Family Member/Community Committee:
INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

CRITERION 4 – CLIENT/FAMILY MEMBER/COMMUNITYCOMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

Client/Family Member/Community Committee: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

The county shall include the following in the CCPR:

A. Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

Policy #01-01-207 (Cultural Competence Resource Team) establishes a Mental Health Services (MHS) Cultural Competence Resource Team (CCRT) to advise the Deputy Directors of Adult/Older Adult and Children's Mental Health Services on issues of cultural competency.

The CCRT is an advisory board operating at the behest of the Mental Health Director (MHD). The Committee consists of a Chairperson (also the Ethnic Services Manager) and twenty (20) voting members, four (4) Subcommittees, and an Executive Committee. The Executive Committee consists of the Subcommittee Chairpersons and the CCRT Chair. The CCRT meets monthly for 1 ½ hours on the first Friday of the month.

Membership is chosen in such a way as to be representative as possible of the Mental Health community. The recruitment procedure is as follows:

1. CRITERIA FOR SELECTION

A. Candidates will be recruited from San Diego, a rich, culturally-diverse community, which is not limited to, but will include:

i. County Regions
ii. County Contractors
iii. Community Hospitals
iv. United Behavioral Health (UBH) Programs
v. Community Services Programs
vi. Consumer/Community Organization (adult & youth)

B. Candidates will have demonstrated a sincere interest in cultural diversity (resume, if applicable) and an expressed interest in promoting the Cultural Competence Resource Team's agenda (written letter, with paragraph on why candidate desired to become a member).

The CCRT shall consist of no more than 20 active, voting members and an unspecified number of Inactive Honorary members. Active members are appointed by the Mental Health Director (MHD). Inactive membership and Honorary members can be designated by the CCRT Chairperson and the MHD.

C. Candidates can become active members in one of three ways:

i. Direct appointment by the MHD;
ii. Active participation on a Subcommittee task force project, followed by a recommendation by Subcommittee Chairperson; or
iii. Recommendation by CCRT Chairperson.

2. ACTIVE MEMBERSHIP

Active membership shall be reserved for those members who are committed to:

A. Thorough review of the Cultural Competence Plan for County Mental Health and a commitment to read all materials pertinent to CCRT.
B. Attend CCRT monthly meeting (notify CCRT of any absences)
C. Accept assignments to one or more of the three subcommittees and assume role in the subcommittee's task force projects.
D. Willingness to take advantage of every opportunity to actively promote and support the goals of the CCRT.

3. INACTIVE MEMBERSHIP

Inactive membership shall be reserved for those persons who have served as an active member for two or more years and for personal or professional reasons are unable to attend the CCRT meetings on a regular basis.

Inactive members agree to act as a consultant, as well as to promote and support the goals of the CCRT in the workplace and the community. Membership can be activated by written request to the Chair.

4. HONORARY MEMBERSHIP

Honorary membership shall be reserved for those persons in the community who have outstanding achievement in the Cultural Competence arena, and who support and promote the goals of the CCRT.

All levels of membership entitle the holder to receive CCRT minutes and newsletters.

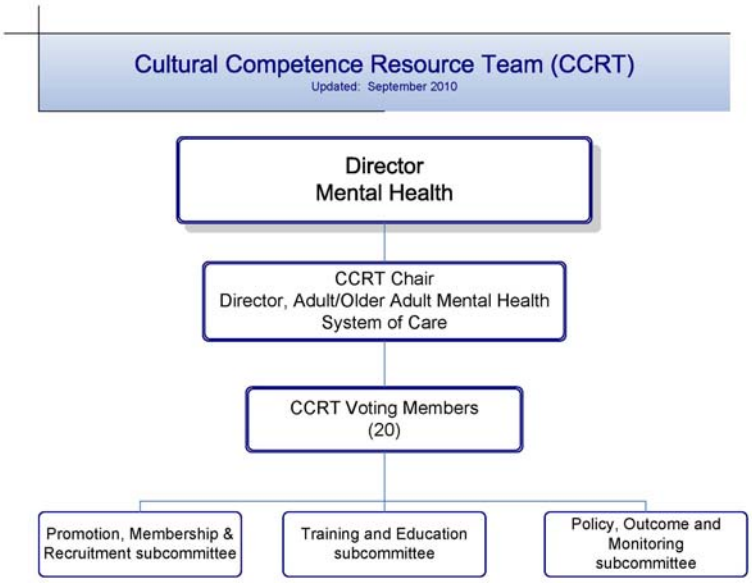
Inactive and Honorary members have an open invitation to attend all CCRT meetings, at their convenience.

B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

Policy #01-01-207 (see p.4) assures that members of the CCRT are reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members, as necessary. The policy states that members of the resource team shall be appointed by the Deputy Directors of MHS and that appointees be from various organizational units and disciplines within MHS, as well as member-at-large appointees from the community including consumers and family representatives. Representation from key groups such as, County Mental Health Quality

Improvement, the Clinical Staff Association, the Mental Health Contractors Association, and the Mental Health Board will be requested to be appointees.

C. Organizational chart



D. Committee membership roster listing member affiliation, if any.

Member	Organization
Anderson, Kathy	Behavioral Health Services, QI/PO
Andrews, Laura	Mental Health America
Beck, Clyde	Scripps/CHID
Camarena, Juan	Community Research
Chavarin, Claudia	Behavioral Health Services
Davis, Al	Consumer
Galapon, Dixie	Union of Pan Asian Communities (UPAC)
Garcia, Piedad	Behavioral Health Services
Gonzaga, Alfie	Behavioral Health Services, SOC
Heller, Rick	Health Services Research Center
Kaleem, Musa	Recovery Innovations (RICA)
Khurana, Bindu	Optum (United Behavioral Health)
La Gardy, la Rita	Neighborhood House
Lang, Tabatha	Behavioral Health Services, SOC
McPherson, Michael	Mental Health Board
Milow, Candace	Behavioral Health Services, QI
Ng, Euphemia , LCSW	Volunteer
Osuyos, Roberta	SDSU
Rodriguez, Nancy	Children's Mental Health System
Sanchez, Nicole	CASRC
Swan, Maureen	RICA
Thomas, David	UCSD HSRC
Webber, Mercedes	RICA

Client/Family Member/Community Committee:

INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System.

The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence at the county;

Policy #01-01-207 (Cultural Competence Resource Team) and Policy #01-01-203 (Culturally and Linguistically Competent Services: Assuring Availability) demonstrates that the CCRT is integrated within the County Mental Health System through the following charges and activities: (Appendix, Criterion 4, pp. 4.II.A.1-6)

The charge of the CCRT is to serve as the "eyes, ears and conscience" of the County of San Diego's Mental Health Services system regarding the development of cultural competence in the delivery of mental health services to culturally diverse populations and system-wide adherence to the local Cultural Competency Plan. The CCRT is a formal mechanism for providing to both organizational and contracted individual providers input and feedback on cultural competence. (#01-01-207) Members provide such input collectively through the Team and conversely bring the message of the CCRT to the community organizations, committees, councils and advisory boards to which they belong.

To provide a context for CCRT members to evaluated proposed changes or issues facing the SDCMHS, a practice has been implemented of briefing the CCRT at the beginning of most meetings about the economic and regulatory realities at the State and their expected influence on the County.

The CCRT meets monthly and includes discussion with respect to cultural competence issues at the County such as: Adult and Older Adult Services; Children's Services; Education and Training; Policy and Program Development; Health Care Disparities; California Mental Health Planning; etc.

In recent years, the following procedures and practices have been implemented to enhance the CCRT activities including:

- Presenting an annual services review through presentation of data from QI Workplan Evaluation Report which includes staff linguistic and cultural proficiency, participation in cultural competency trainings, consumer satisfaction survey results, etc.
- An annual retreat has afforded CCRT members the opportunity to learn, in greater depth, about new initiatives that the SDCHMS is considering and to hear reports on the successes or failure of initiatives undertaken, and system and client outcomes. The CCRT then charts its course for the next year and also has the opportunity to make recommendations on impending service changes with an emphasis on cultural competence and improving services for cultural and linguistic minorities. The CCRT also uses the retreat as a time to review its current ethnic/racial and cultural composition and considers changes to reflect the changing demographics and needs of San Diego.

The CCRT also contributed to the development of practices which are increasing the emphasis

on culturally competent programming being a priority.

- The Team participated in the planning, formulation and review of the Disparities Report, "Progress Toward Reducing Disparities FY 2001-02 to FY 2006-07" which dealt with changes in cultural disparities in the mental health system over a five year period. Information from a variety of reports was consolidated to concisely present a picture of services by age group and ethnicity/race. This report will be updated every 3 years.

- The CCRT and its Education Subcommittee recognized the need for and assisted in the development and adoption of the CC-PAS tool for providers to use for organizational cultural competence self evaluation.

2. *Provides reports to Quality Assurance/Quality Improvement Program in the county;*

County Mental Health Services, with the guidance of the CCRT, will ensure ongoing progress toward meeting service availability based on the cultural and linguistic needs of the population of San Diego County requiring mental health services. (Policy #01-01-203).

There is a close linkage between the CCRT and the Quality Improvement Unit of the SDCMHS. The Director of the Quality Improvement is a lead member of the CCRT and other QI Performance Outcomes staff participate on the Committee also to be sure that the two-way exchange of information is maintained.

In the monthly meetings of the CCRT there is a regular agenda item on Quality Improvement during which time topics are discussed such as: Cultural Competency Evaluation Tools for the System Programs and Staff; San Diego County Mental Health Services Yearly Data Book; Client Assessments and Reports; Quality Review Audits; Electronic Medical Records System Training (Anasazi); Culturally Competent Program Annual Self-Evaluation (CC-PAS); etc.

CCRT members have informally provided reports back from various Councils, meetings and conferences attended which increases the Team's and QI's understanding of the community. To encourage more information interchange, the CCRT is beginning to include a standing agenda item for such cross reporting. CCRT members will have a time to share handouts from other meetings and to relay community concerns and needs.

The CCRT Policy and Program Subcommittee has also made some suggestions for improving program cultural competence which would in turn improve quality and accessibility. The following suggestions have been relayed to MH Administration:

- Consider requiring programs to have extended service hours to help adults and parents who are employed be able to access services.
- Research and develop programs and/or interventions to reach out to Asians and Pacific Islanders.
- Conduct needs assessments by region
- Institute more skills based training for existing staff.
- Utilize consumer/stakeholder input to define culturally competent services.
- Posting information on the county's Technical Resource Library (TRL) or Network of Care Website and consider implementing Discussion Boards or Blogs.

3. *Participates in overall planning and implementation of services at the county;*

The CCRT participates in overall planning and implementation of services at the county through analysis of demographic information to determine or identify gaps in service provision and assurance that cultural and linguistic needs are considered in strategic plans, human resource training and recruitment, and contracting requirements.
(Policy #01-02-203)

Overall planning and implementation of services in San Diego County continues to be regularly discussed at CCRT meetings, covering target areas such as:

- Access to Care – the need to continue with multiple efforts to engage culturally and ethnically diverse individuals who are unserved or underserved
- Evidence Based Practices – the need to continue to measure success of EBP put into place on integrated physical health and mental health services and dual diagnosis services in areas of diverse populations
- Workforce Development – the need to evaluate expansion of cultural competence education to include establishing community liaisons or culture brokers to enhance its outreach to diverse underserved populations
- Evaluation and Outcomes – the need to identify a set of standards or elements that would encompass defining criteria that would go beyond what is being currently required, possibly using EBPs as interventions with specific outcomes
- Quality of Care – the need to identify and evaluate a set of specific quality of care standards that would inform the administration on how well we are meeting the needs of ethnically diverse clients in our system.

The CCRT has also participated in ongoing input and review of the development and implementation of all phases of the MHSA Plans. Since the last CCP in 2003-04, the largest effort, by far, that has been made to augment, improve, or start-up new services has been made possible through the Mental Health Services Act funding. The CCRT, through its members and through its Ethnic Services Manager participated in the development of the Community Services and Support Plan and the Prevention and Early Intervention Plan. The CCRT continues to maintain its interest in reports on the outcomes of services implemented to benefit ethnic/racial/ and cultural minorities. The CCRT has also provided feedback on suggested uses of Enhancement funding for the CSS Plan. The Ethnic Services Manager continues to carry CCRT's concerns to SDCMHS Executive Core meetings. CCRT input, additionally, was carried into mulitple phases of the MHSA process, through member participation on the Children's, Adults, the TAY Taskforce, Older Adult and Housing Councils, and stakeholder and work groups.

The CCRT has also reviewed results of initiatives tried by the SDCMHS. For example, the Team recently reviewed of the UCSD evaluation of the use of promotoras in the community clinics to work with Latino clients dealing with depression and diabetes. The CCRT offered suggestions to improve outcomes, including the need for closer integration of promotoras with the treatment teams.

The CCRT is also considering how it could have an informal electronic mental health chat room or join in on an existing one. Staffing and maintenance of the site are limiting factors which will be investigated.

The CCRT maintains a committee structure to allow for more in-depth input and discussion. For example, the CCRT Policy and Program Subcommittee has made some suggestions for improving program cultural competence which would in turn improve quality and accessibility. These suggestions have been relayed to MH Administration:

- Develop web-based training to ensure that more people get the same training, as well as being able to access the trainings at convenient times and locations.
- Establish a program model for cultural competent programs.
- Post the System's cultural competence philosophy at each program site.

4. *Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;*

San Diego County's commitment to cultural competence in policies and practices is documented in excerpts from CCRT meetings which have been included in the Appendix, Criterion 4, pp. 4.II.A.7-43.

The CCRT transmits recommendations to the executive level by providing recommendations to the Ethnic Services Manager and the Director of QI, who sit on the SDCMHS Executive Core Team and can directly relay recommendations from the CCRT to the Mental Health Director.

The CCRT works with QA/QI program on performance outcomes and standards for assessing the mental health system's cultural competence in servicing culturally diverse populations and recommending data collection strategies. The CCRT is able to recommend corrective action when the system's performance does not meet expected standards of cultural competence. (Policy #01-01-207)

After reviewing reports and recognizing the limited progress that the County has made in increasing the availability of services to cultural and ethnic minorities in our system of care, the CCRT will take a more pro-active stance on ensuring that concerns and recommendations to SDCMHS administration are addressed, including the following:

- Inviting the Mental Health Director to attend meetings twice yearly or as needed to advise him of questions, problems seen, and proposals, centering on cultural competency.
- Ask the SDCMHS administration for a report on whether programs are successfully serving their target populations.
- Ask the SDCMHS administration what its goals are for reaching racial/ethnic and cultural minorities through mental health programs and recommend that a goal of a specific percentage improvement be established.
- Establish a process for Executive level review of CCRT recommendations (contained in meeting minutes), with the CCRT to track follow-up.

5. *Participates in and reviews county MHSA planning process*

The CCRT participated in the development of the MHSA planning process. Presentations were made directly to the Team by the MHSA staff. The CCRT has contributed to and reviewed the ongoing County MHSA planning process through participation in stakeholder groups, the Children, Adult, and Older Adult Councils. Additionally, the views of the CCRT are also reflected by the Ethnic Services Coordinator, ADDs and QI in all Executive planning committees. For an example of the CCRT participation in reviewing the County MHSA planning processes, please see the CCRT Meeting Minutes for September 4, 2009, provided in the Appendix, Criterion 4, pp. 4.II.A.29-32.

6. *Participates in and reviews county MHSA stakeholder process;*

- The CCRT, as discussed above has participated in the SDCMHS MHSA stakeholder input process both as a group and as individual members. The CCRT members serve on a variety of different stakeholder groups including the Children's Adult, and Older Adult Councils, the TAY Workgroup, the Housing Council, the Family/Youth Roundtable, etc.
- On the Committee level, the CCRT Education & Training Committee provided input to the Behavioral Health Training and Education Committee to on education and training needs for cultural and linguistic minorities.

For evidence of the CCRT's participating in and reviewing county MHSA stakeholder processes, see the attached CCRT Meeting Minutes from December 7, 2007, May 2, 2008, and January 8, 2010 in the Appendix, Criterion 4, pp. 4.II.A.9-16 and 33-34. The CCRT has not participated and reviewed the stakeholder process per se, but they have provided input and feedback when the MHSA Team has made presentations about the stakeholder process.

7. *Participates in and reviews county MHSA plans for all MHSA components;*

For evidence of CCRT participation in and review of County MHSA plans for MHSA components, see the attached CCRT Meeting Minutes from November 2, 2007, December 7, 2007, July 9, 2008, August 1, 2008, and September 5, 2008 located in the Appendix, Criterion 4, pp. 4.II.B.7-12 and 17-28.

8. *Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and*

Members of two leading client/client family operated agencies—Recovery Innovations of CA and the Family Youth Roundtable serve on the CCRT, bringing their unique expertise to all discussions. Two member of NAMI from different regions bring in the perspective of family members, as does a CCRT member from the Child and Adolescent Services Research Center. Examples of the CCRT's participating in and reviewing client developed programs can be found in the CCRT Minutes from July 9, 2008 and August 1, 2008, located in the Appendix, Criterion 4, pp. 4.II.A.17-24.

9. *Participate in revised CCPR (2010) development.*

The purpose and structure of the CCRT supports the local Cultural Competence Plan as mandated by the State Department of Mental Health, as can be seen in Policy #01-01-207, included in the Appendix, Criterion 4, pp.4.II.A.1-2.

The CCRT has been participating in the revision of the CCPR (2010), devoting half or more of its meeting time between June and September, 2010 to giving input, feedback, and final review of portions of the CCPR, as they became ready. The Education and Training Committee, additionally, focused its meetings on working on the development of a training plan, in conjunction with the Behavioral Health Training and Education Committee. An example of CCRT activity in this area ca be found in the excerpt of Minutes from June 4, 2010 below. For additional pages of Minutes, please see the Appendix, Criterion 4, pp. 4.II.A.35-36.

CULTURAL COMPETENCE RESOURCE TEAM
MEETING MINUTES
June 4, 2010

- The subcommittee is currently working on Criteria 5 for the Cultural Competence Plan (2010) regarding training and cultural competence. Once this is completed the committee will provide update to the CCRT for their input and feedback.

B. Provide evidence that the Cultural Competence Committee participates in the above review process.

As discussed and documented above in Sections 1-8, San Diego County's CCRT's participates in the review process for County MHSA planning process.

- County MHSA stakeholder process
- County MHSA plans for all MHSA components
- Client developed programs (wellness, recovery, and peer support programs

Evidence from CCRT meeting minutes from November 2, 2007, December 7, 2007, May 2, 2008, July 9, 2008, August 1, 2008, September 5, 2008, September 4, 2009, and January 8, 2010 has been included in the Appendix, Criterion 4, pp. 4.II.A.7-34.

C. Annual Report of the Cultural Competence Committee's activities including:

i. Detailed discussion of the goals and objectives of the committee;
ii. Were the goals and objectives met?
iii. if yes, explain why the county considers them successful
iv. if no, what are the next steps?
v. Reviews and recommendations to county programs and services;
vi. Goals of cultural competence plans;
vii. Human resources report;
viii. County organizational assessment;
ix. Training plans; and
x. Other county activities, as necessary

In conjunction with the Annual Retreat, the Ethnic Services Coordinator reviews and updates the Annual Report twice yearly, discussing whether goals and objectives were met and whether the efforts were successful. An example of the Mid Year Status Update of the FY 08-09 Annual Report is given below:

Cultural Competence Resource Team (CCRT)

ANNUAL REPORT

FY 08 -09 MID YEAR STATUS UPDATE

on CULTURAL COMPETENCE PLAN OBJECTIVES

Based on the discussions and themes presented at the CCRT Retreat in 2006 the following objectives were the focus of attention for the fiscal years 06-07 through 11-12.
FY 2007-2008 – updated through out the FY
FY2008-2009 – 6 month update

Objectives	Mid year FY 08-09 Status Update	Next 6 Month Goals 2008-2009	Plan	Timeline and Lead	Status 2007 -2008	Status Update as of 1/9/09
1. ACCESS TO CARE						
• Analyze gaps	MHSA Gap Analysis and updates GIS Mapping	▪ Website post Gap Reports	Create binders with all Gap analysis info to date and distribute to MH Admin and Council leads. Make reports available in PDF on website so that more can access data. Provide MHSA GAP Data for remaining	PEI - January 08 - CM PEI – November 08 – Final workplans presented @ CCRT for input and submitted to MHB, BOS and DMH. WET – 07-08 Needs Assess. Feb.08 – SDSU/The Academy	- Completed - Binders were completed and distributed. - Completed - Reports have been changed in PDF format. - Not included in Website -Performance Outcome delivered Gap	Completed: ▪ Gap analysis for MHSA/Binders provided ▪ MHSA gap analysis for CSS, PEI and WET Plans provided ▪ Final WET needs assessment posted on Network of Care in Dec. 08.

Objectives	Mid year FY 08-09 Status Update	Next 6 Month Goals 2008-2009	Plan	Timeline and Lead	Status 2007 -2008	Status Update as of 1/9/09
			MHSA components.	Nov. 08 – SDSU/Finalizing phase 2. Final report from MHS administration pending. **Lead** = TL/ CM/MHSA Admin.	- Completed Draft WET Needs Assessment was presented to CCRT in May 2008 - TL	
• Conduct access studies of diverse groups	Latino Access to Care Older Adults TAY		Provide data analysis for past 3 yr. Provide data analysis " " " Provide data analysis " " "	Annually – 07-08 " " " " **Lead** = CM By June 08	- Completed - analysis for Latinos, Older Adults, and TAY - Completed - AOA Data Report. To be presented to CCRT in Nov. 08	Completed: ▪ Analysis for diverse populations for SOC, TAY, Older Adults ▪ AOA Data Report 06-07 and 07 - 08
• Improve access to care to reduce mental health care disparities	Wait Times Penetration Retention Length of Stay Analysis by Dx to identify disparities	Identify Disparities 07-08 data by July 09	Provide data analysis for past 3 yr. " " " " " " Implement the use of an standard MH assessment as part of assessment processes in new settings	Annually FY 06-07 FY 07 – 08 **Lead** = CM By June 08	- Data available for FY 06 -07 - FY 07-08 available Jan.0 9 - MH Screenings have been implemented for AD S programs and for CCC	Completed ▪ Wait times – MHB Report Card – Monthly ▪ Penetration and retention – QI provided in November 08 ▪ 100% of clients screened/assess for co-occurring disorders
2. EBP	**Mid year FY 08-09 Status Update**	**Next 6 Month Goals 2008-2009**	**Plan**	**Timeline and Lead**	**Status 2007 -2008**	**Status Update as of 1/9/09**

Objectives	Mid year FY 08-09 Status Update	Next 6 Month Goals 2008-2009	Plan	Timeline and Lead	Status 2007 -2008	Status Update as of 1/9/09
• Identify and provide CC interventions to access to care and reduce disparities in mental health care.	IMPACT Promotora ACT Incredible Years Trauma Focused CBT Motivational Interviewing Other from CIMH list or other resources	▪ Evaluate 1 Adult Program ▪ Evaluate 1 Children's Program ▪ Evaluate 1 Older Adult Program ▪ CCC evaluation ▪ Action Item: Project Enable – Piedad to follow up w/redesign team. Need update by June 09	Identify standardized CC clinical practices and/or adopt/adapt that support recovery/resiliency model Evaluate the practices currently being implemented for fidelity IMPACT model embedded in North County Mental Health Clinics to increase integration with physical health clinics.	By Winter of 2008 **By end of 08-09** **Lead** = Program and Policy Co. with assistance from contracted Research Centers	- CCRT Policy subcommittee has been reviewing EBP but has been unable to complete the analysis. - Tools to evaluate some of the current practices have been identified - Completed for ACT Fidelity programs only - New North County contracts, with Impact language, to be executed January 1, 2009.	Completed ▪ ACT Fidelity ▪ Co-occurring disorders fidelity Which tools? ▪ New North County programs implemented. ▪ Impact baseline to be established July 2009.

Objectives	Mid year FY 08-09 Status Update	Next 6 Month Goals 2008-2009	Plan	Timeline and Lead	Status 2007 -2008	Status Update as of 1/9/09
• Provide integrated holistic services	MH/PH integrated services Dual Diagnosis Services/Dually Capable and Enhanced Programs. ACT services		Identify standardized CC clinical tools and/or adopt/adapt Evaluate the practices currently being for fidelity	By Winter of 2008 **By end of 08-09** **Lead** = Program and Policy Co.	- CCRT Policy subcommittee has been reviewing EBP but has been unable to complete the analysis. - Tools to evaluate some of the current practices have been identified. ACT and Co-occurring disorders,	Completed: ▪ Co-occurring disorders for dually capable programs (need list and present to CCRT) ▪ ACT Services (need list and present to CCRT) In progress: ▪ MHS/Primary Health Care ▪ Children's Programs

3. WORKFORCE DEVELOPMENT	Mid year FY 08-09 Status Update	Next 6 Month Goals 2008-2009	Plan	Timeline and Lead	Status 2007 -2008	Status Update as of 1/9/09
• Identify and provide culturally competent education and training within a multi-level approach.	Training Plan	Latino Access to Care Study – Report Update Write Next 3 Salud Articles: Input needed: Children/Youth Family ? Children's Update Report for Family Roundtable ?	Establish Behavioral Health Services Training & Education Committee (BHSTEC)	Present Training & Ed. Plan to Director and establish 1st meeting By Feb. 08 **Lead** = PG	- Completed. BHSTEC meets monthly. Decision making process flow chart developed. Group is evaluating training provided by BHS. - Staff training survey conducted & completed in 08-09. - WET process to begin in Dec. 08	Completed: ▪ Establish BHSTEC – Piedad Garcia chairs – ADS, Children and AOSOC represented. Hospital and M.D. is represented via Clinical Director. ▪ Administration will add section to address missing elements in training. Recommendations PSR and CC Training/Academy. ▪ Training Survey for county and contractors ▪ WET Report Phase I & II ▪ Older Adult Geriatric Certificate. In Progress ▪ WET process underway in Fall 08. Submit to State by May 09 ▪ CC training component in draft for Piedad's input and feedback via BHSTEC.

• Develop a stigma reduction campaign	Latino Access to Care Study	Status Update/QI Engagement in Services/Retention	Continue to enhanced gains	**Lead** = CM	- Completed.	Completed: • Status Update of Latino to Care and Access requested
	Breaking Down Barriers	Status Update/TL Action Item: July Meeting presentation evaluation/outcomes	08-09 Focus on Latinos and LGBT, TAY and OA Subpopulations	**Lead** = TL for FY 08-09	- SOW has been amended to reflect outreach to expanded populations.	▪ Breaking Down Barriers – TL
	Salud & Health Info	3 new articles on recovery by end of June 09/PG RICA will be writing articles on recovery: 1. Client Recovery 2. Recovery of Consumer, Peer and Family Perspective 3. Peer Recovery & Staff	6 MHSA and PEI articles in Spanish and English.	**Lead** = PG and Yael for FY 07-08	1st - MHSA Overview 2nd – Stigma and Access to Care 3rd – Children & Stressed Families 4th – Domestic Violence 5th – Your Doctor and Health Care 6th – Stigma & Discrimination	▪ Salud & Health Info – Six articles completed. ▪ Three more articles for next year on Recovery.
	Client and Family Liaison Prg.	CMH status update of activities by end of June 2009	Consumer and Family client forums	**Lead** = PG and Yael by June 08	*3 add. Issues for FY 08-09 -Completed - Meaningful Consumer Integration (MCI) Committee established in Central, North County and East regions.	▪ Established and in progress in Central Region, North County and East County Region via MCI and PIC.
			Ensure SD participates in Statewide Stigma campaign	**Lead** = PG & All RPC's and Chiefs for 08-09	- DMH has finalized	▪ Stigma & Discrimination Initiative – Piedad Garcia leads for AOASOC as local lead for

		Provide status update by May 2009			guidelines. Stigma and Discrimination Initiative to include MHS, stigma, suicide and Spirituality and Recovery Conference in Southern Regions in planning stages by CIMH for June 09. PG lead	o Housing Stigma & Discrimination . SOW in develop. o Philip Hanger for Access to Care MHS, Suicide Prevention. SOW in development.
• Establish a community liaison staff in programs	Not implemented in 06-07 Proposed in PEI Workplans for 08-09 PAGs	▪ PAG's Need to focus more on PSR and recovery practices in programs as members of PAGS ▪ RPC's to follow up with PAG's.	Explore MHSA funding for contract expansion for this function.	By 3. 08 **Lead** = PG	- Completed - Community liaisons added to PEI workplans. C/A and OA in 08-09 for impl. In 09-10 -Most programs have PAG's in 08-09	Completed: ▪ MHSA funding used in Breaking Down Barriers contract and MHSA/PEI programs, to include Veterans, Native American, Older Adults, Rural Services, Domestic Violence & LGBTQ. ▪ Piedad visited 80% of PAG's with RPC's in 07/09 and 08-09. All conduct meetings differently and different agenda and focus. ▪ PAG's Need to focus more on PSR and recovery practices in programs as members of PAGS
• Identify culture brokers	Not implemented in 06-07 Proposed in		Explore MHSA funding for contract expansion for this function in 07-08	By 3.08 **Lead** = PG	- Completed - Culture brokers/commu. liaisons established for NA and Rural, VETs with PEI in	▪ Completed through MHSA/PEI workplans.

	07-08 Completed in 08-09				08-09 to be imp. in 09-10 - Requested additional culture brokers for LGBTQ and East A-Co. 09-10	• Completed for 09-10
4. EVALUATION OF OUTCOMES	**Mid year FY 08-09 Status Update**	**Next 6 Month Goals 2008-2009**	**Plan**	**Timeline and Lead**	**Status 2007 -2008**	**Status Update as of 1/9/09**
• Evaluate cultural competence capability of programs	Workforce Development	• Draft of CC Training Modules by June 09/TL • QI to provide status of program and self evaluation tools for implementation post pilot test And set next steps?	Capacity building. Present proposal at Councils	By June 08 **Lead** = PG for Adult KA for Children	- Completed. WET Needs Assess. Phase 1. Finalized Phase 2. ID need to increase diversity in workforce. To be presented at all Councils.	Completed: ▪ WET Community Needs Assessment Phase I & II In Progress: ▪ Cultural Competence Training Plan components in draft and in process ▪ Candace Milow – Program/self evaluation tools in draft. ▪ What are next steps?
• Evaluate interventions/outcomes	Evaluate EBPs	▪ Evaluate EBP for culturally diverse populations UPAC M. Sardinas Project Enable Children's Programs?	Identify CC/EBP in use for diverse populations. Track, trend and evaluate as to next steps	By Winter 08 **Lead** = CM and PG and KA	- CCRT Policy subcommittee has been reviewing EBP but has been unable to complete the analysis due to multiple priorities. i.e., MIS	Not Completed: 1. New outcome tools Completed by QI

	Evaluate FSPs				- Outcome measures and tools to evaluate some of the current practices have been identified. - SAMHSACo-occurring dis. Fidelity completed. - FSP/ACT Fidelity completed. . - OA – Impact at CCC subcontracts with UCSD	Current tools and outcomes on ▪ SATS- R MHRTS, Employ/Ed homelessness/ housing 2. Evaluate EBP for diverse OA and Latinos, i.e. IMPACT, next steps 3. MHSA/FSP Data workplan outcomes ▪ Hospital/legal system, homelessness, employment and education ▪ Quality of Care and Satisfaction
• Evaluate environments for appropriateness and informational materials in threshold languages	Site Review	▪ Sample Review	Conduct program site/record review	By June 08 **Lead** = CM	- Site reviews were completed. A report on results will be available in Sept 08. ???	Completed ▪ Site Reviews – ongoing and acceptable for most with corrective action. ▪ No report for all completed, not able to do - can spot check
5, QUALITY OF CARE	**Mid year FY 08-09 Status Update**	**Next 6 Month Goals 2008-2009**	**Plan**	**Timeline and Lead**	**Status 2007 -2008**	**Status Update 1/9/09**
• Assess culturally competent quality of care	Evaluations of programs	▪ Named Tools o Impact – report o Primary Care & MHS Integration o Children?	Data analysis for diverse pops. to include demos, hospitalization, types of services received, penetration, retention and client satisfaction	By Fall 08	- Tools to evaluate some of the current practices have been identified however the CCRT Policy subcommittee has been reviewing	Can evaluate • Some programs via site reviews and data analysis • Client satisfaction survey • MSR's

		o Other ▪ Provide FY 07-08 & FY 08-09 via MHSA Quarterly Reports to CCRT ▪ Increase number of outcomes – pending baseline in 2010 - not at this time.	survey. Other elements to consider is id. CC normed tools and pilot to assess client functioning and improvement	Id. normed tools by Fall 08, Pilot by Winter 08. Evaluate Pilot Programs by Winter 09 **Lead** = CCRT Program and Policy Co., and CM	methods of evaluation but has been unable to complete the analysis.	▪ No specific tools available to evaluate programs/clients for quality of care. Only client satisfaction survey ▪ New outcomes tools to be introduced to assess client recovery, stability, improvement – will change in 2010 ▪ What else – Next steps with MHSA/CSS & PEI
• Increase access and quality of care in other languages	New MHSA Programs-	Get copies of report from QI for April 09	Evaluate and analyze new MHSA programs Chaldean & ME Social Services Trauma and Victims of Trauma Deaf and Hard of Hearing African communities	By Winter 08 **Lead** = CM	Initial MHSA report has been completed for 06-07 but specific programs were not evaluated. Will work to ensure this is done for the 07-08 update	▪ Quarterly report submitted to State – CCRT needs to get copy of last 07-08 & 08-09 for client and by listed program for first 2 quarters in 08-09
	Increase number of Outcomes Increase representation in MH meetings, programs,		Ensure Integration of clients and family members in SOC and increase client/family operated programs across SOC:	By June 08 **Lead** = PG, RPC's and Chiefs	MHS and QI Id., and approved new outcome tools to be implemented in 2010-2011 with new MIS system - Completed Consumer participation via Client Liaison contract in CCRT, Core Group, A & OA Councils, Housing	▪ Pending -New tools in effect within 2 years. Currently using existing tools for MHSA outcomes reporting. • Completed: PIC RICA SD NAMI PAG's, Consumers embedded in multiple MHSA Administrative Meetings.

		▪ Peer Specialist Survey Report by June 2009	Evaluate and ensure client/family participation in: Client/Family operated programs MHS administration meetings MHSA Implementation Councils CCRT PAG's QRC Peer Specialists as staff in programs		Council, MHSA Planning Committee, and PAGs. - PG – has attended approx., 80% of PAGs in 07-08. PG to provide overview of findings. - CSS & PEI programs added Peer Specialist in services. - Core and New RFP's require Peer paid staff	• Most programs have different format with different focus. • WET Needs Assessment Report findings. Additional program survey completed by Piedad. Results to be provided by June 2009

Other:
Update Cultural Competence Plan
Create a Cultural Competence Report
Develop a Cultural Competence Handbook
Updated for FY 08-09 - Mid Year

Summary of Pending Tasks
FY 09/10
FY 10/11
FY 11/12

Compilation of pending CCRT Objectives based on Cultural Competence Plan Objectives document in 2007-2008

Access to Care
- Analyze Gaps
- Conduct access studies of diverse groups
- Improve access to care to reduce mental health care disparities

- Health Care Disparities Report completed with recommendations. **Need to id., priorities and timelines**
- Penetration and retention – QI provided in November 08. **Need Update for FY 08-09.**

EBP
- Identify and provide CC interventions to improve access care and reduce disparities in mental health care.
- Provide integrated holistic services

- Focus on client measures and outcomes identified, to be implemented in 09-10. **Need update from QI**
- IMPA**CT** Intervention**- baseline to be provided by the CCC**
- Co-occurring disorders for dually capable programs - **Provide list and present to CCRT**
- ACT Services – **Provide list and present to CCRT**
- MHS/Primary Health Care Integration, i.e. IMPACT and care coordination. **Need update/CCC**
- Children's SOC **follow-up**

Workforce Development
- Identify and provide culturally competent education and training within a multi-level approach
- Develop a stigma reduction campaign
- Establish a community liaison staff in programs
- Identify culture brokers

- Stigma and discrimination campaign – Housing, Spirituality & Recovery, Fotonovela and MHSA Suicide Prevention – **ongoing, provide status report**
- QI Health Care Disparities Report – **Training recommendations TBD**
- Evaluated PAGS and RICA will work with PAGS to increase consistency in purpose across all PAGS in programs. – **Ongoing, provide status report**

Evaluation of Outcomes
- Evaluate cultural competence capability in programs
- Evaluate EBP & outcomes
- Evaluate environment for appropriateness and informational materials in threshold languages

- Cultural Competence Training Plan components in draft and in process for RFP. **MHSA/BHSTEC leads**
- Program/self evaluation tools identified and to be implemented in 09-10 **QI to provide update**
- Pending - MHSA/FSP Data outcomes for 08-09 **QI to provide data**
- Material in threshold languages - **QI to provide update**

Quality of Care

- Assess culturally competent quality of care
- Increase access and quality of care in other languages

- New outcomes measures introduced in 2009-2010 to assess client recovery, stability, improvement – **QI update**
- MHSA/CSS & PEI client outcomes for 2009-2010 - **Identification in progress**
- CCRT to get **copy from QI of last 2 FY 07-08 & 08-09 quality of care outcomes**
- FY 09-10 baseline for new outcome tools - **QI to provide update**
- RICA in October 2009.

Sources of information:

Organizational bylaws, meeting minutes, interviews of committee members, and annual reports of Quality Assurance/Quality Improvement Department

CRITERION 5

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

CULTURALLY COMPETENT TRAINING ACTIVITIES

CRITERION 5 – CULTURALLY COMPETENT TRAINING ACTIVITIES

CULTURALLY COMPETENT TRAINING ACTIVITIES

I. The county system shall require all staff and stakeholders to receive annual cultural competence training.

The county shall include the following in the CCPR:

A. The county shall develop a three-year training plan for required cultural competence training that includes the following:

1. The projected number of staff who need the required competence training. This number shall be unduplicated.

1. Approximately 2,400 unduplicated mental health staff including: county and contracted unlicensed direct service staff; licensed mental health staff; psychiatrists; nurses; volunteers; managers and support staff need to have a minimum of four (4) hours of cultural competence training annually.

2. Steps the county will take to provide cultural competence training to 100% of their staff over a three year period.

2. For almost ten years now, the SDCMHS has shown growth in reaching the target of 100% of staff trained in cultural competence by requiring County and contract staff, including support staff dealing with clients, to receive 4 hours of cultural competence training each year. This requirement is contained in the Organizational Providers Operations Handbook which is a part of each contract. The SDCMHS has contracted out the vast majority of its services, ranging from hospitalization to outpatient services for all age groups. County and contract providers are responsible for obtaining/providing the required four hours of cultural competence trainings for their staffs.

Under development is SDCMHS's four prong approach to expanded training. It is believed that the approach, described below, can move the County forward from the current State Department of Mental Health expectations in a deliberate and planned fashion. The approach takes into consideration the economic and environmental climate with the advent of the National Health Care Plan.

First Prong--County and Contractor Self-Provided Trainings

- Trainings are provided through the County Knowledge Center for County employees at no cost and a small number of providers on a fee basis.

Cultural Competence Trainings Offered by the County Knowledge Center:

CULTURAL COMPETENCE TRAININGS		**FY10-11**		
CC training modules/title	CC training focus/description	# of classes planned for FY10-11	Total # of hours	Delivery type (lecture/classroom, web/computer based, blended learning)
Cross Cultural Classes-	*See list below for class titles*	10	40	All classroom with possibility of one e-learning class
Diversity Training *Embracing Diversity & Encouraging Respect*	Based upon 3 key change areas: Ensuring representation, understanding & valuing differences, and leveraging diversity, the County is pursuing a diversity strategy that is focused on tapping into the talents, skills and commitment of its workforce. Embracing Diversity & Encouraging Respect is a key part of this strategy.	200+	400	classroom

Below are some of the specific cultural competency topics planned for 2010-2011:

Code	**Cross-Cultural Courses**	**Date Offered**
HH1580	Filipinos & Mental Health	October
HH1560	African & Middle Eastern Cultures	November
HH0104	American Indian Populations	December
HH1584	Disability Awareness Training	January
hh1562	Latino Culture: Spotlight on Mexican-Americans (New!)	February
HH1586	Bridging Gender Differences (New!)	March
HH5926	Chaldean Culture and the Impact of Trauma on this Population	April
	TBD	May
	TBD	June
	TBD	July

Over the next three years, HHSA the Knowledge Center (TKC) plans to offer about 30 cultural competency trainings ranging from 4-8 hours in length for which SDCMHS County Staff can access.

Several of San Diego County's larger contractors, including Community Research Foundation (CRF), New Alternatives, and Mental Health Systems, Inc. (MHS) offer their own Cultural Competency Training to their own programs to meet the 4 hour requirement. Their courses are also offered to agency staff and also to the public-- on a fee basis. An example of such training is the Mental Health Systems, Inc. training titled "Cultural Competency 101 – Awareness and Understanding." This class is a four-hour introduction to concepts and theories of culture. Participants are presented with demographics and information which demonstrated MHS' commitment to cultural sensitivity, raising cultural awareness and interactive opportunities for participants to become aware of their own cultural values, beliefs and assumptions. This content is presented to include organizational and individual elements of cultural competence and activities which facilitate integration and application.

The Training Objectives are to:

- Increase knowledge and understanding of diversity and cultural competence
- Describe concepts of identity and diversity
- Explore three theoretical models of cultural understanding
- Integrate principles into personal and professional practice

Second Prong--SDCMHS Contracted Trainings Through BHETA

The SDCMHS contracts with the Behavioral Health Education and Training Academy (BHETA) at San Diego State University to offer free clinical, administrative, and cultural competency trainings to County and contract BHS staff. While BHETA classroom training is limited in size, some of the courses are starting to be offered on-line. In FY 09-10, BHETA offered 14 online courses totaling 36.5 hours. One on-line class is titled "Cultural Competency BHD0001" which is a three hour e-learning class that provides an introduction to cultural competency and resiliency in Behavioral Health. The class provides an overview of culture, a method of self-assessment, and introduces the use of cultural assessment in treatment. Participants complete the California Multi-Cultural Competency Scale (CBMCS) at the end of the class.

The SDCMHS is working with BHETA to increase access to trainings by offering a broader array of web-based training. Using web-based training would enable staff on all shifts, at all provider sites, to access training on-site at their convenience. Locating trainings on the web will also allow other stakeholders to access training information. It is expected that a plan for these trainings will be available in late FY 10-11, with additional web-based trainings possible in FY 11-12. Through BHETA, it is anticipated that 1190 unduplicated staff members will be trained in nine Cultural Competence (CC) trainings in FY10-11 and FY11-12.

Third Prong--SDCMHS Cultural Competence Academy Intensive Training

Through the SDCMHS WET Plan, a Cultural Competence Academy for San Diego Mental Health Services will provide a more intensive training initiative to further the objectives identified by the Cultural Competency Resource Team (CCRT). The **Cultural Competence Academy** (CCA) will be offered once or twice annually, to provide cultural competence awareness, knowledge and skill based trainings to a minimum of 120 county and contracted mental health staff on all levels each fiscal year. The Academy will consist of an in-depth intensive 32-40 hour course that will yield a Certificate of Completion for individual staff. Training will be provided on Awareness, Knowledge, and Skills Development. This curriculum is designed for agencies and programs that want to exceed their basic current cultural competence requirement and acquire the SDCMHS Cultural Competence certification. Programs that opt to take the Cultural Competence Academy training and ensure at least 75% of program staff have been trained will be certified as Culturally Competent and Proficient Programs (CCPP).

The CCA certification demonstrates that the Program has the following characteristics:

- Has completed a Cultural Competence Program Assessment— evidence: a completed CC-PAS (see CC-PAS sample in Appendix, Criterion 5, pp. 5.I.A.1-8)
- Has completed Cultural Competence Staff Self Assessment—evidence: completed CBMCS (see CBMCS attachment in Appendix, Criterion 5, pp. 5.I.A.9-10)
- CC staff that is reflective of the community they serve--Report
- Had needed bilingual capability – evidence Monthly Status Report
- Has Agency/Program Cultural Competence Plan – Document on file

- Participates on Cultural Competence Program Team –evidence: minutes/agenda/membership on file
- Has Policies and Procedures that institutionalize Cultural Competence at all levels of the organization—evidence: document review
- Conducts specific culturally competent clinical/service interventions that are complimentary and are best practices—evidence: Medical Record Review
- Complimentary CC interventions are documented in medical records—evidence: Medical Record Review.
- Conducts community activities to engage unserved and underserved ethnically diverse populations—evidence: documentation on Monthly Status Report
- Documentation that demonstrates that 75% of staff have completed CC Academy Training—evidence: CC Academy certificate
- Maintains outcomes that demonstrate functional and clinical improvements to include: client satisfaction, penetration and retention rates.
- Conducts clinical supervision on CC relevant issues – evidence: documentation Medical Record Review

For reference, the SDCMHS Three Year Training Plan for FYs 2010-11 and 2012-13 has been included in the Appendix, Criterion 5, pp.5.I.A.11-17.

Fourth Prong--WET WORKFORCE BUILDING ACTIVITIES

The goal of the WET Plan is to build an education and training structure that supports growing and maintaining a public mental health workforce consistent with MHSA and WET fundamental concepts, to have a culturally competent workforce, including clients and family members, capable of offering client- and family-driven wellness, recovery, and resilience-oriented services within an integrated service experience. The following programs are being implemented:

Specialized Training Modules: This action is designed to increase the number and diversity of trainings offered to San Diego County's public mental health workforce. The training modules outlined below support the core competencies for the public mental health workforce, the philosophy of client and family-driven services that promote wellness, resilience, and recovery-oriented services that lead to evidenced-based, value-driven outcomes. Cultural diversity must be incorporated into staffing, environment, and service delivery models. Additionally, in the WET Needs Assessment, providers associated life stages as another area related to cultural sensitivity training, since each age group presents with unique challenges and issues that require special knowledge, skills and competencies. In accordance with this consideration, training may also be aligned with targeted population groups such as Early Childhood, Youth, Transition Age Youth, Adult, and Older Adults, as well as culturally, linguistically and ethnically diverse communities where appropriate. Due to an increased need for providing services to children ages 0-5, early childhood specific mental health training will be addressed as appropriate by the Children's Mental Health System of Care. This will include skill based training for service providers working with this early childhood population. Additional trainings may be added to meet the future demands of the County of San Diego mental health workforce.

- **Public Mental Health Academy:** This action uses multiple strategies to reduce barriers to employment and create opportunities for individuals, including consumer and family members, to become part of San Diego County's public mental health workforce. The Academy is intended to be a collaborative, community-based educational academy with two distinct but related pathway tracks that lead to certification, skill development and employment in the public mental health workforce:

  1) Public Mental Health Credential/Certificate Pathway for potential future and incumbent mental health employees in a variety of direct services occupations, both licensed and unlicensed direct positions.

  2) Consumer Family Pathways to assist consumers and family members become members of the public mental health workforce.

Both pathways have been designed to create a pipeline of professionals who have the skills to deliver services based on the principles of recovery, wellness, and consumer and family involvement.

- **School-Based Pathways/Academy:** In order to promote mental health careers to students, this action will create a partnership between the County of San Diego and San Diego County schools to implement a mental health component/track similar to the established Health Care Pathways programs which will primarily be offered at the high school level with some career exposure opportunities at middle school level. As conceived, the Academy will create linkages to public mental health careers through curriculum development and integration with core academic subjects. In addition, exposure to careers in the variety of public mental health occupational areas through internships, career speakers and job shadowing will be explored. The schools that will be targeted will include those whose enrollments of students include a high number of students who are linguistically, culturally and economically diverse.

  Partnering with the educational system to expand Health Care Pathways, career counseling and outreach to diverse economic, cultural and ethnic communities will be included. The SDCMHS will have the opportunity to increase the diversity of the mental health workforce while also reducing the stigma associated with mental illness. Additionally high school students can be encouraged to consider public mental health occupations. The intended result is an increase in the number of high school students who choose to pursue mental health careers. Exposure to occupations including both clinical and non-clinical direct positions will increase student interest in occupations that serve particular areas of need, e.g., early childhood, transition age youth, adult, and older adult, as well as cultural and linguistic diversity.

- **Nursing Partnership for Public Mental Health Professions:** The County of San Diego will partner with local higher education institutions that offer programs in a variety of nursing pathways/areas to expand the capacity for developing additional public mental health professionals in nursing occupations that are most needed. Programming would be coordinated with existing nursing pathways at local institutions of higher education. The County of San Diego may pursue leveraging and program opportunities to ensure appropriate priority for nursing partnerships.

  The County's WET Needs Assessment identified the following areas of need in nursing: Clinical Specialists, Licensed Vocational Nurses, Registered Nurses, and Psychiatric Nurse Practitioners. For this action, the schools that will be targeted will include those whose enrollments include a high number of students that are linguistically, culturally and economically diverse. Nursing partnerships will also include, as a priority, programs/pathways with curriculum that focuses on particular age groups in need - early childhood, youth, transition age youth, adult, and older adults, as well as culturally, linguistically and ethnically diverse communities, since each group presents unique challenges and issues that require special knowledge, skills and competencies. Academic instruction would be coupled with practicum and mentorship opportunities with public mental health contractors or with the County of San Diego.

- **Community Psychiatry Fellowship:** The WET Needs Assessment revealed a significant shortage of psychiatrists who work in San Diego County and in particular, community psychiatrists who have received training in the public mental health system and the wellness and recovery model. This program is directed toward remedying this shortage by exploring the possibility of partnership with a medical school to fund a position(s) with the intent of increasing family medicine/psychiatry fellows with a community psychiatry specialization. To launch this fellowship, it is anticipated it will be necessary to fund additional faculty time for training in community psychiatry, as well as additional supervision time for the fellow(s). In addition, we will provide fellowship training that stresses the wellness and recovery model, raises awareness about the philosophy of inclusion of consumers and family members in service delivery and increases their knowledge of multicultural issues and the diverse community to be served. For this action, the program may target those individuals that are linguistically, culturally and economically diverse. This will be based on the need of the workforce.

- **Child Psychiatry Fellowship:** The WET Needs Assessment revealed a significant shortage of psychiatrists who work in San Diego County and in particular, child psychiatrists who have received training in the public mental health system and the wellness and recovery/resiliency model. This action is directed toward remedying this shortage by exploring the possibility of a partnership with a medical school to fund a position with the intent of increasing family medicine/psychiatry fellows with a child psychiatry specialization. To launch this fellowship, it is anticipated it will be necessary to fund additional faculty time for training in child psychiatry, as well as additional supervision time for the fellow. In addition, we will provide fellowship training that stresses the wellness and recovery model, raises awareness about the philosophy of inclusion of consumers and family members in service delivery, and increases knowledge of

- **LCSW/MFT Residency/Intern:** Training and mentoring of licensed clinicians is essential for promoting MHSA philosophies and values of recovery, resilience and wellness. While many graduate degree programs have already implemented this type of training (e.g., graduate social work students concentrating in public mental health are offered a curriculum embracing a comprehensive range of competencies consistent with the MHSA including recovery, wellness, culturally and linguistic services, etc.), this action is directed at increasing the presence of licensed individuals in San Diego County. The SDCMHS will explore developing a partnership with established MSW and MFT training program(s) to fund residency/internship slot(s) to offer students compensation in exchange for a commitment to practice in San Diego County's public mental health workforce. It is anticipated that implementing such a position would also require making funding available for supervision of position(s).

- **Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff:** This action is designed to aid in the recruitment and retention of license eligible and culturally, linguistically and/or ethnically diverse public mental health staff to work in both the County and contracting community-based organizations (CBOs). Stakeholders in the WET planning process spoke determinedly of the need for a more culturally competent, linguistically proficient, and ethnically diverse workforce.

- Providing financial incentives for licensable workers and individuals with specific cultural/linguistic proficiencies and/or ethnic identifications serves the dual purpose of ensuring sufficient licensable staff and a diverse workforce. The focus of the action is on offering stipends, scholarships and/or loan assumptions in order to recruit and retain qualified mental health workers in return for a commitment to employment in the County's public mental health system. Financial incentives may also be given to qualified intern supervisors to ensure interns are receiving a positive learning experience within the public mental health system.

3. How cultural competence has been embedded into all trainings.

All trainings of any sort provided through the SDCMHS are required to have a cultural competence component. These trainings range from those conducted by BHETA, QI, HHSA, and the Knowledge Center to System of Care trainings by contracted training organizations. Guidelines for BHETA (the largest provider of trainings for the SDCMHS) are given below:

GUIDELINES FOR BHETA TOPICS

Behavioral Health Services Training and Education Committee (BHSTEC), the hub for training planning in the Behavioral Health Services (BHS) system, drives the training topics that contractor BHETA implements each fiscal year.

BHSTEC's role is to make recommendations to BHS about education and training needs across the three sectors of Behavioral Health Services (Adult, Children, ADS).

- To ensure that education and training consistently meets the objectives of the system at the program and direct service level.
- To consider workforce development training needs based on the MHSA, WET report
- To analyze and evaluate current trainings and redundancies.

GUIDELINES FOR BHETA TRAINERS

(Ethics, Standards & Performance)

The following guidelines encompass the guiding ethics, values and training principles applicable to the trainers with the Behavioral Health Services Education Training Academy (BHETA). BHETA holds all trainers and coordinators accountable to these principles in our work of delivering training to behavioral health staff, clients, and their families.

1. **CORE VALUES**:

A. Every effort should be made to ensure the physical and emotional safety of all trainees.
B. Learning and development: facilitate knowledge acquisition; skill demonstration and practice; utilize strategies to promote transfer of learning; and, advocate for the development of learning organizations/communities.
C. Cultural Competence: promote competence in understanding the uniqueness of individuals within their environment and recovery.
D. Integrity: Promote a climate of trust and mutual respect.

2. **ETHICAL STANDARDS**:
   A. **Consumer/Client Focused**:
      i. Advocate for the well-being of consumer clients.
      ii. Preserve and promote the dignity of clients discussed in training and development activities.
      iii. Maintain the confidentiality of clients during training activities.
      iv. Provide training activities that help trainees better understand and promote recovery of consumers, clients and their families.
      v. Promote the philosophy of resilience and self reliance in consumers, clients and their families.
   B. **Participant/Trainee Focused**:
      i. Recognize, protect and where possible, enhance the dignity and worth of all trainees.
      ii. Clarify expectations regarding:
         - training goals
         - roles of those involved in training activity
         - rules/policies impacting trainee
         - interpersonal behavior in the classroom
      iii. Provide a safe learning environment
         - Where content areas have the potential for causing emotional reactions, have a plan on how to handle reactions that support the trainee without distracting other trainees from their learning process.
         - Promote a climate of trust and mutual respect in training so that trainees feel supported enough to take risks to promote their learning and development.
      iv. Promote trainee acquisition of knowledge and skills.
      v. Help trainees plan for application of learning to the job.
   C. **TRAINER PERFORMANCE**
      i. **Training Design**:
         - Demonstrate ability to write appropriate content for the instructional objectives.
         - Demonstrate ability to organize instructional material in sequencing, integration of theory and practice, pacing of material, and depth of material in relation to audience.
         - Demonstrate the information to be delivered is relevant, current, based on evidence based practice, current research, literature and/or law review and best practice.
         - Demonstrate the ability to integrate BHS specific information and/or values.
         - Demonstrate understanding of adult learning theory in designing curriculum.
         - Incorporate a variety of methodologies to enhance learning.
         - Demonstrate the ability to use feedback and evaluation data to revise training curriculum.
      ii. **Integration of BHS Themes**:
         - cultural competence
         - resilience
         - recovery
         - integrated co-occurring treatment
         - Wrap-around
   D. **Competencies During Presentation of Training**:
      i. **Training Delivery:**
         - Demonstrate mastery of subject matter to be presented in curriculum
         - Make effective use of multiple presentation styles (lecture, facilitated discussion, small group breakouts, role plays, case examples, technology, and handouts) to illustrate key points in training.

NOTE: Not all presentation styles need to be incorporated during the training day; Technology may include the use of video clips, music, power point presentation, etc.
- Clearly state identified competencies and learning objectives
- Manage conflict
- Encourage audience participation
- Create an environment where participants feel safe to explore ideas or disagree
- Provide clear instructions for activities
- Provide learning opportunities for the variety of learning styles defined by Adult Learning Theory

Policies shall be developed and implemented to ensure that all trainings for mental health services are consistent with mental health philosophy and principles. Training standards shall be developed that include cultural competency being embedded in trainings as appropriate.

CULTURALLY COMPETENT TRAINING ACTIVITIES

II. The Annual cultural competence trainings

The county shall include the following in the CCPR:

A. Please report on the cultural competence training for staff. Please list training, staff, and stakeholder attendance by function (if available, include if they are clients and/or family members).

1. *Administration/Management;*
2. *Direct Services, Counties;*
3. *Direct Services, Contractors;*
4. *Support Services;*
5. *Community Members/General Public;*
6. *Community Event;*
7. *Interpreters; and*
8. *Mental Health Board and Commissions; and*
9. *Community-based Organizations/Agency Board of Directors.*

Contractors are required to report on trainings attended by staff on their Monthly Status Reports. The County compiles summary statistics on the training attendance by extracting this data from over 200 MSRs for each of 12 months. This data rolled into an Access database and is aggregated across the system. However, the topic/description of individual trainings is created by each provider, since providers are responsible for their own cultural competence trainings. The result is somewhat inconsistent across providers in classification of training topics. The tallying system also does not make an allowance for staff who may have left the field during the year without finishing training requirements. In addition, some trainings may have been given by a legal entity and reported separately by individual programs attending. The SDCMHS collects data on: the topic or description of the training (as self-reported), course length, attendance by function, total attendees/provider/training, the course date and the program reporting. The data is scrubbed to remove duplicate entries for staff working at more than one program—a common occurrence. It should be noted that in smaller programs, the Program Manager may be functioning both as an administrator and providing direct services, creating additional duplication. This data gathering process is very time consuming and labor intensive. Because of labor constraints at both provider sites and in the SDCMHS offices, the name of presenters are not able to be captured at this time, nor have we been able to categorize trainings by the eight State-named types given in item B. below.

At present, the SDCMHS does not have the capacity to provide training to community members/general public, interpreters, community based organizations/agency board of directors. By FY 12-13, if our web-based training modules are fully up and running, we expect to be able to provide much broader access to trainings which may include these groups.

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. *Cultural Formulation;*
2. *Multicultural Knowledge;*
3. *Cultural Sensitivity;*
4. *Cultural Awareness; and*
5. *Social/Cultural Diversity (Diverse Groups, LGBTQ, SES, Elderly, Disabilities, etc.);*
6. *Mental Health Interpreter Training;*
7. *Training staff in the use of mental health interpreters;*
8. *Training in the use of interpreters in the Mental Health Setting.*

In FY 2008-09, providers reported 991 incidences of trainings-some web-based and others in classrooms. 71% of the entire SDCMHS program staff completed the required four hours of training. 74% of direct service staff completed the required four hours of training, 80% of administrative staff, and 61% of support staff, and 56% of volunteers. It should be noted that the direct service staff were required to attend a significant number of trainings on the SDCMHS transition to a new management information system which limited their available time for other trainings in FY 09-10.

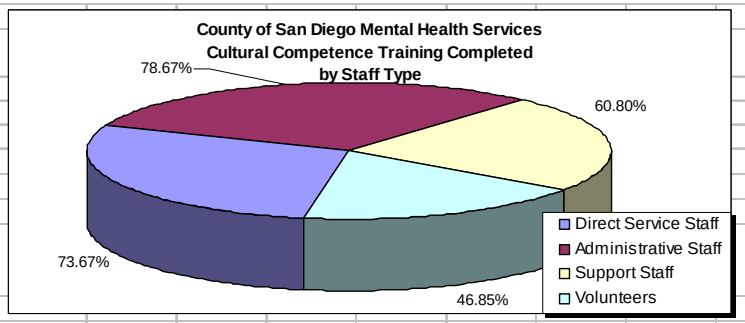
Examples of trainings in the eight topic areas are:

Topic #	Title	Provider
1	Exploring Cultural Communication:	Rady's Children's Hospital
1	A Culture Centered Approach to Recovery	Heritage Clinic
2	Multicultural Issues in Art Therapy	Rady's Children's Hospital
2	Multicultural Training Day	Community Research Foundation
3	Cultural Sensitivity	Community Research Foundation
3	Cultural Competency (Sensitivity)	New Alternatives
4	Culture and Ethnicity Awareness	Jewish Family Service
4	Culture, Awareness, and Knowledge	Mental Health Systems, Inc.
5	Addressing the Need of Youth Who Are LGBTQ	Family & Youth Roundtable
5	Mental Health in Older Adults	Mental Health America—San Diego
6	Interpreter Training	Union of Pan Asian Communities
6	Working Effectively with Healthcare Interpreters	County of San Diego
7	Interpreter Training	Union of Pan Asian Communities
7	Working Effectively with Healthcare Interpreters	County of San Diego
8	Interpreter Training	Union of Pan Asian Communities
8	Working Effectively with Healthcare Interpreters	County of San Diego

An excerpt of the SDCMHS Training Report (an 82 page document) has been provided in the Appendix, Criterion 5, pp. 5.II.B.1-10.

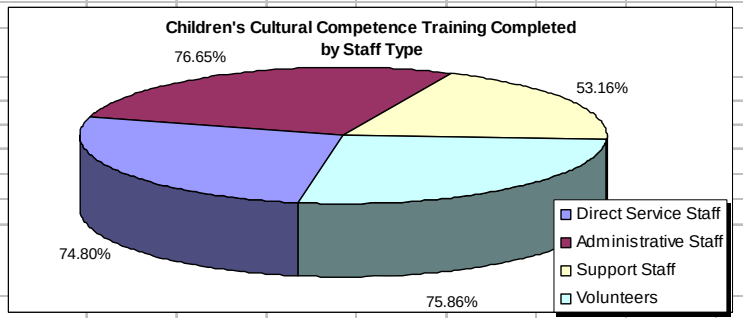
Systemwide					
	Admin FTE	Direct FTE	Unduplicated Individuals	Completed CC Training	% Completed CC Training
Direct Service Staff	35.47	1057.49	1808	1332	73.67%
Administrative Staff	143.65	36.97	300	236	78.67%
Support Staff	188.93	0.00	301	183	60.80%
Volunteers	0.05	10.60	111	52	46.85%
Total	368.10	1105.06	2520	1803	71.55%

Total No. of CC Trainings	Average Course Length	Administration or Management	Direct Services	Support Services	Volunteer or Student Workers
494	3.81	299	1257	196	79



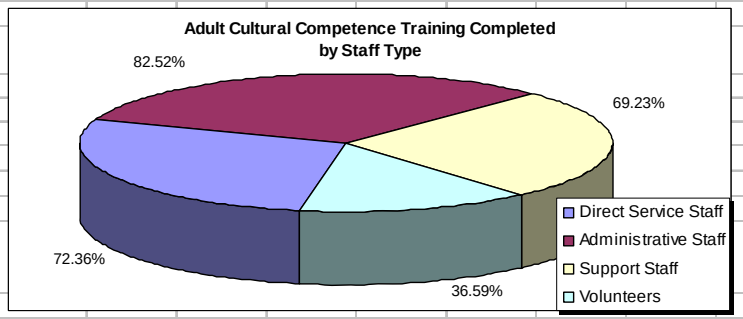
Children					
	Admin FTE	Direct FTE	Unduplicated Individuals	Completed CC Training	% Completed CC Training
Direct Service Staff	6.48	566.04	976	730	74.80%
Administrative Staff	92.11	13.50	197	151	76.65%
Support Staff	88.365	0	158	84	53.16%
Volunteers	0	0.25	29	22	75.86%
Total	186.96	579.79	1360	987	72.57%

Total No. of CC Trainings	Average Course Length	Administration or Management	Direct Services	Support Services	Volunteer or Student Workers
494	3.81	299	1257	196	79



Adult/Older Adult					
	Admin FTE	Direct FTE	Unduplicated Individuals	Completed CC Training	% Completed CC Training
Direct Service Staff	28.99	491.45	832	602	72.36%
Administrative Staff	51.54	23.47	103	85	82.52%
Support Staff	100.56	0	143	99	69.23%
Volunteers	0.05	10.35	82	30	36.59%
Total	181.14	525.27	1160	816	70.34%

Total No. of CC Trainings	Average Course Length	Administration or Management	Direct Services	Support Services	Volunteer or Student Workers
496	4.48	283	1209	165	86



Note: Individuals may serve in more than one program or in some agencies serve in an administrative and direct service capacity.
2) Providers may receive training through a variety of sources. Figures in this report have been self reported by programs. Also the
3) Trainings vary in length. Persons may attend more than one cultural competence training.

Use the following format to report the above requirements:

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
Example *Cultural Com-petence Intro-duction*	*Overview of cultural competence* *settings.*	*Four hours annually*	**Direct Services* **Direct Services Contractors*	*15* *20* *2* *Total: 41*	*1/24/10*	

See Training Report Excerpt in the Appendix, Criterion 5, pp. 5.II.B.1-10

CULTURALLY COMPETENT TRAINING ACTIVITIES

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

A. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

1. Rationale and need for the trainings: Describe how the training is relevant in the addressing identified disparities

Rationale:

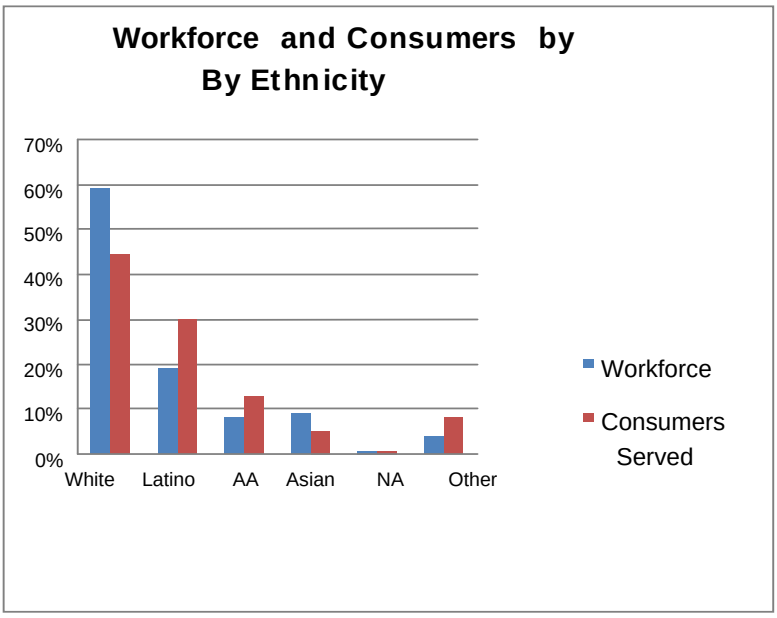
"The Institute of Medicine (IOM) report, *Unequal Treatment* [1], recommended that all health care professionals should receive training in cross-cultural communication—or cultural competence—as one of multiple strategies for addressing racial/ethnic disparities in health care. This recommendation emerged from robust evidence highlighting the fact that the failure of health care providers to acknowledge, understand, and manage socio-cultural variations in the health beliefs and behaviors of their patients may impede effective communication, effect trust, and lead to patient dissatisfaction, nonadherence, and poorer health outcomes, particularly among minority populations. Similarly, another IOM report, *Crossing the Quality Chasm* [2], noted that patient-centered care — particularly its attributes of being respectful of patients' values, beliefs, and behaviors — is an essential pillar of quality." (Excerpt reposted directly from http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Commentary__Linking_Cultural_Competence_Training.14.aspx)

Formulating a training curriculum has been a developmental process for the SDCMHS. It is understood that Cultural Competence (CC) trainings improve the attitudes, knowledge, and skills of providers. Culturally competent interventions that are embedded in best practices or promising practices, such as IMPACT and Salud, also improve patients' ratings of care. Through the Disparities Report, discussed previously, the SDCMHS has been able to pinpoint some of the inequalities which need to be addressed. This report has been brought to the planning groups in the CCRT and moves have been made to start addressing the disparities. The BHETA group, the CCRT Education and

Training Committee, and BHS Training and Education Committee have been working together to create coursework curricula to address disparities, as outlined in the Cultural Competence Training Plan.

Need:

Approximately 57% of the SDCMHS population is ethnically diverse, while only 41% of the workforce is. The profile of the provider staff and the SDCMHS client profile are dissimilar, as can be seen from the chart below reproduced from the WET Needs Assessment, pg.12. The need for staff to receive cultural competence training is apparent in order to have clinicians/direct service staff be able to work as effectively as possible with their clients.



Note: The vast majority of the Asian component of the workforce is Japanese, while the client population is largely Vietnamese, Cambodian, Hmong, Lao, and Samoan.

2. Results of pre-post tests (Counties are encouraged to have a pre/post test for all trainings);

SDCMHS contractors are also encouraged to have pre/post tests for their trainings. The HHSA Knowledge Center and BHETA utilize pre and post-tests routinely for Cultural Competency Courses. CRF, MHS and New Alternatives provide their own cultural competency training for their staff. Samples of pre and post-tests are included in the Appendix, Criterion 5, pp. 5.III.A. 1-3.

3. Summary report of evaluations; and

Since almost one thousand incidents of trainings (both web-based and classroom) took place throughout this large County and were provided by a variety of providers, there has not been a summary report of evaluations created, to date. SDCMHS is weighing how such a report could be done and the labor involved in aggregating the data both by provider and by the County.

*NOTE: BHETA, along with other training departments of service provider agencies, have the capability to provide summary of trainings they provide.

*NOTE: HHSA Knowledge Center retains the evaluation data on all cultural competency classes, which are reviewed to influence the selection of future instructors and topics. This data is utilized for annual report that is submitted to the State.

4. *Provide a narrative of current efforts that the County is taking to monitor advancing staff skills/post skills learned in trainings.*

The County is working with providers to rate their own agency's cultural competence through the Cultural Competence-Program Annual Self-Evaluation; it is expected that improvement will be seen as staff advance in their cultural competence skills. Staff competence can also be measured by annual administration of the California Brief Multicultural Competence Scale (CBMCS), which is a tool recommended for usage by provider in the Organizational Provider Operational Handbook; over time, staff scores should show incremental improvement.

This year, for the first time, some staff in adult programs partcipated in the Recovery Self Assessment which included questions rating ther agency's cultural competence. The results are as follows:

In 2010, to help identify San Diego County A/AOMHS' Cultural Competence on a program level and as a system, RSA items related to cultural competence were examined. A sample of 216 respondents submitted returns; this number was too small to allow us to compile information on a program level, but rather the data was looked at systemically. A sample of approximately 20 County staff also rated the system as a whole.

RSA Subscales—Cultural Competence Orientation

Question	Item wording	% Agree or Strongly Agree	
		County Staff	Providers
Q 9	All staff at this agency regularly attend trainings on cultural competency.	93.3%	90.2%
Q 26	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	86.7%	84.5%
Q 10	Staff at this agency listen to and follow the choices and preferences of participants.	86.7%	80.8%
Q 23	Staff play a primary role in helping people in recovery become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education.	84.6%	69.8%
Q 6	People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work.	80.0%	77.5%
Q 16	Staff are knowledgeable about special interest groups and activities in the community.	86.7%	76.9%
Q 1	Helping people build connections with their neighborhoods and communities is one of the primary activities in which staff at this agency are involved.	73.3%	69.0%
Q 2	This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.	93.3%	74.9%
Q 25	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization.	84.6%	73.4%
Q 7	Most services are provided in a person's natural environment (i.e. home, community, workplace).	64.3%	55.7%
Q 30	People in recovery work along side agency staff on the development and provision of new programs and services.	64.3%	50.3%
Q 19	This agency provides a variety of treatment options (i.e. individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.	30.8%	56.7%
Q 17	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	27.3%	39.5%

5. *County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.*

The SDCMHS intends to use the CC-PAS, the CBMCAS, and the RSA tools discussed above to measure change in the levels of cultural competency on a provider and staff person level. To measure the effectiveness of cultural competence training over time, the QI Unit is planning to update the Disparities Report every three years, anticipating positive changes in retention and penetration rates as MHSA programming becomes fully operational. A requirement for contractors to have a Cultural Competence Plan, and to conduct the CC-PAS and CBMCAS annually is being added to new and existing contract language as re-procurements are completed.

CULTURALLY COMPETENT TRAINING ACTIVITIES

IV. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

The county shall include the following in the CCPR:

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:

- *Cultural-specific expressions of distress (e.g., nervous);*
- *Explanatory models and treatment pathways (e.g., indigenous healers);*
- *Relationship between client and mental health provider from a cultural perspective;*
- *Trauma;*
- *Economic impact;*
- *Housing;*
- *Diagnosis/labeling;*
- *Medication;*
- *Hospitalization;*
- *Societal/familial/personal;*
- *Discrimination/stigma;*
- *Effects on culturally and linguistically incompetent services;*
- *Involuntary treatment;*
- *Wellness;*
- *Recovery; and*
- *Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.*

The SDCMHS contracts with the Behavioral Health Education and Training Academy (BHETA) which, in turn, has a contract with a client run organization called Recovery Innovations of California (RICA) to provide training on adult client culture described by RICA as follows: :

> This one-day training provided participants with an understanding of client culture. The training provides an overview of recovery and resilience. Resiliency and culture differences are highlighted for participants through personal stories told by multicultural consumers. The trainer discusses recovery culture through presentation and video. Family members and consumers share their experiences in the mental health system for greater understanding of the consumer perspective. A panel discussion further enhances understanding and awareness.
>
> Learning objectives:
>
> - Describe the benefits of creating an environment supportive of recovery
> - Discuss recovery within a multicultural consumer base
> - Describe the consumer/family experience of the mental health system

- Delineate the reasons to include family members in treatment planning

Four one day trainings were given to approximately 80 mental health providers in FY09-10.

"Consumer Client Culture Training" provides seven hours of continuing education credits for MFTs/LCSWs as required by the California Board of Behavioral Sciences and also qualified for County Cultural Competency Requirements. It has been presented several times each year and components can be changed, as needed.

The NAMI contract has the following objectives:

- A minimum of 40 individuals will complete family education (10 two hour classes)
- A minimum of 90 clients will participate in peer education training to encourage client awareness of mental illness, coping skills, resources available, and mutual support possibilities (10 two hour classes)
- A minimum of 10 people will complete the peer education "train-the trainer" course
- Family education materials are available in English, Spanish, Vietnamese, and Arabic. Peer education materials are available in English and Spanish.

The Family Youth Roundtable contract also provides a quarterly Principles to Family/Youth Professional Partnership course to a minimum of 30 administrative and /or direct service staff for an annual minimum of 120 participants. The training's goal is to introduce and educate administrative and direct service staff about the value of incorporating family/youth partners at different program levels.

In addition, The Consumer Family Pathways Program is currently in the planning stage and will include: Provider Education Training conducted by consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and family members trained as Family-to-Family Education Program teachers who have been certified through the NAMI Provider Education Training. This series of trainings will focus on current providers in the public mental health system. A penetrating, subjective view of family and consumer experiences with serious mental illness, this training helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness. Such training, focusing on family culture, client culture and provider culture, will also play an important role in educating contract agencies and County operated programs as to the benefits of hiring and advancing consumers.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's personal experiences with the following:

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency

1. An example of family-focused treatment is the 1.5 hr training titled "Families Stand Together" offered by Family Youth Roundtable.
2. The SDCMHS contracts with Family Youth Roundtable (FYR) to provide the Employment Training Academy whose goal is to provide training that enhances

contractors' skills in hiring family/youth as part of their workforce. Contained within the "Academy" is an element called "Pathways for Partnership" for family and youth audiences which include information on navigating multiple agency services.

"This 40-hour training covers **navigating multiple agency services.** Pathways for Partnership guides family members and youth who have had involvement with public systems, from being a recipient of services to opening opportunities to become a "partnership broker." This training teaches family members and youth to utilize their experience "as a recipient of services from a public child-family serving system" to assist other family members, youth and providers to better understand the cultural differences, system mandates, and roles within a Children's System of Care for Family and Youth partners. This training provides an in-depth review of roles for family/youth involvement, as well as prepares recipients to serve family and youth receiving services, to identify resources, linkages and support systems that assist in recipients in meeting treatment goals. Furthermore, this training supports a cohesive foundation of the roles and responsibilities of Family & Youth Partners, thus providing the community with consistency in training and an organized service-delivery support for the advancement of Family-Youth-Professional Partnership.

3. Training on resiliency is included in the web-based BHETA Cultural Competence BHD0001, a three hour class providing an introduction to cultural competence, discussed previously.

Use the following format to report the above requirements:

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
Example *Cultural Com-petence Intro-duction*	*Overview of cultural competence settings.*	*Four hours an*	**Direct Services *Direct Services Contractors*	*15 20 2 Total: 41*	*1/24/10*	

See Training Report Excerpt in the Appendix, Criterion 5, pp. 5.II.B.1-10

San Diego County Mental Health Services

CULTURAL COMPETENCE TRAINING PLAN

For County and Contracted Program Staff

3 YEAR TRAINING PLAN

FYs 10-11 through 12-13

San Diego County Mental Health Services
CULTURAL COMPETENCE TRAINING PLAN
FYs 10-11 through 12-13

INTRODUCTION

The San Diego County Mental Health Services (SDCMHS) Cultural Competence Training Plan establishes a plan for training for Mental Health services staff for the next three years. The Cultural Competence Training Plan (CCTP) includes the underlying assumptions for developing the training plan as well as a description of participants, training topics, and curriculum. The CCTP also provides an overview of the goals of planned training and linkage to strategic SDCMHS initiatives. Finally the CCTP includes plans for an evaluation of the impact of training. It is notable that for providers in San Diego training takes place in many venues; however this CCTP addresses only training planned and provided by SDCMHS.

Assumptions:

The SDCMHS Cultural Competence Training Plan is predicated upon certain assumptions which are critical to its success.

- The first assumption is that there should be stakeholder involvement in the development of the training plan. The primary vehicle established to facilitate such involvement is the BHSTEC and the Cultural Competence Resource Team (CCRT) Such participation has a direct influence on the validity and reliability of training content, and is the most efficient way to ensure that the needs and special circumstances of the users are adequately and realistically represented.
- The second assumption is that in order to be transformational Cultural Competence training
- The third assumption is that training must have a measurable results and effectiveness

Participants

The Training Plan outlines the contents of the training program which has been designed by the County to meet the needs of individuals identified in three categories: Clinical/Direct services staff, Administrative and Management staff, and Clerical staff.

These participants represent the services that are offered to Children and Youth (C&A), Transitional Age Youth (TAY), Adults and Older Adult s (A/OA).

Training Topics

Training topics included in the CCTP will include training that address awareness, knowledge and skill development levels

Curricula -

The specific curriculum for each of the training topics is identified in the Training Plan. The curricula is based on needs assessments and targeted areas to reduce disparities that has been identified in the Disparity Report, and the Workforce Education and Training plan.

It is notable that additional training opportunities for additional curricula are provided by contractors and other outside training vendors.

Linkage to Strategic Initiatives/ **Goals**

The CCTP presents the overall goals of the training, and demonstrates linkages to major SDCBHS Strategic Initiatives

Instructional design

The CCTP identifies the planned instructional design including the number of staff to be trained, the instructional design strategy to be employed, and the particular media and methods which will be used for the training: User Manuals, Web or Computer -Based Training, or Classroom Training.

Evaluation

The planned training will be subjected to review and evaluation. Evaluations of training take the following forms:

1. Reaction - What does the learner feel about the training?
2. Learning - What facts, knowledge, etc., did the learner gain?
3. Behaviors - What skills did the learner develop, that is, what new information is the learner using on the job?

The 4th measure to be used for evaluation is still under development:

4. Results or effectiveness - What results occurred, that is, did the learner apply the new skills to the necessary tasks in the organization and, if so, what results were achieved? This will be done for programs completing the Cultural Competence Academy initially with a possibility of being generalized in the future.

    - Evaluating effectiveness will involve the use of key performance measures -- e.g., more access to services by racially and ethnically diverse populations, penetration and retention improvements over base line, use of best practices or promising practices, as well as more clients who are housed, employed or in school.

Mental Health Programs Cultural Competence Training Plan

FY 10-11

Participants	Training Topic	Provided by	Instruction Design	Timeline	Focus	Evaluation
Clinical Staff Basic:	Various Specific Populations (knowledge training)	The Knowledge Center (TKC), Contractors	Varies- All staff are required to attend a minimum of 4 hours annually of cultural competence training annually	2010-2011	LGBTQ, Latino, African American, Asian/Pacific Islanders, Native American, Middle Eastern, Gender Responsiveness	Reaction Learning
	Interpreter Training (skills training)	BHETA	Classroom	Jan 2011	Need for more language assistance	Reaction Learning
	Consumer Culture – Adult/Older Adult (awareness training)	BHETA	Classroom-	March 2011	Sensitivity to client culture for adults /older adults	Reaction Learning
	Consumer Culture – Children, Youth, TAY (awareness training)	BHETA	Classroom-	July 2010 Dec 2010	Sensitivity to client culture for children, youth, and TAY	Reaction Learning
	Family Engagement	BHETA	Classroom	Sept 2010 Jan 2011	Awareness of family, caregiver in treatment planning	Reaction Learning
	Veterans series	BHETA	Classroom	Aug 2010 through Dec 2010	Large population of Veterans in SD	Reaction Learning
	MH Services and the Family—working together	BHETA	Classroom	2012-13	Family Focus in Children's Treatment	Reaction Learning
	Promoting Resiliency in Children and Parents	BHETA	Classroom		Emphasizing strength based services to promote resiliency in families with children and youth receiving mental health services	Reaction Learning
Clinical Staff Intensive	Cultural Competence Academy (knowledge and skills training)		Classroom- five 8-hour training sessions- offered three times per year- 120 Trainees. Selected programs only	2010-2011		Reaction Effectiveness
Participants	Training Topic		Instruction Design	Timeline		Evaluation
Administrative and Management	System overview of CC Plan and the County's Policy and	MH Admin	Leadership Plus Quarterly Meetings Series Presentations	2010- 11	Awareness of policies and cultural competence goals	NA

Staff:	Requirements					
Participants	Training Topic		Instruction Design	Timeline		Evaluation
Clerical Staff:	Training to include: Welcoming attitude Professional demeanor Facilitating interpreter svcs. & translated material Cultural nuances: ➢ Respect for diff. ➢ Comm. Styles ➢ Role of family Addressing stigma & discrimination MHSA training in diversity		Classroom – 4 hrs.			
Participants	Training Topic		Instruction Design	Implementation Timeline		Evaluation
Interpreters	Mental Health Training for Interpreters	BHETA	Classroom training	Jan 2011	Need for more language assistance	Reaction Learning
Parents of Children and Youth	Pathways for Partnership	Family Youth Roundtable	Classroom training	2008 ongoing	Learning to navigate multiple agency services effectively	TBD

Mental Health Programs Cultural Competence Training Plan

FY 11-12

Participants	Training Topic	Provided by	Instruction Design	Timeline		Evaluation
Clinical Staff Basic:	Various Specific Populations (knowledge training)	The Knowledge Center (TKC), Contractors	Varies- All staff are required to attend a minimum of 4 hours annually of cultural competence training annually	2011-2012	LGBTQ, Latino, African American, Asian/Pacific Islanders, Native American, Middle Eastern, Gender Responsiveness	Reaction Learning
	Consumer Culture – Adult/Older Adult (awareness training)	BHETA	Classroom- # of trainees	TBD		Reaction Learning
	Consumer Culture – Children, Youth, TAY (awareness training)	BHETA	Classroom- # of trainees	TBD		Reaction Learning
Clinical Staff Intensive	Cultural Competence Academy (knowledge and skills training)		Classroom- five 8-hour training sessions- offered three times per year- 120 Trainees. Selected programs only	2011-2012		Reaction Learning Effectiveness
Clinical Staff Intensive	Training Topic		Instruction Design	Timeline		Evaluation
Administrative and Management Staff:	TBD		Leadership Plus Quarterly Meetings Series Presentations MHSA Policy MHS Policy Health Care Disparities DMH/CCP Plans	2011-2012		
Participants	Training Topic		Instruction Design	Timeline		Evaluation
Clerical Staff:						
Participants	Training Topic		Instruction Design	Implementation Timeline		Evaluation

Mental Health Programs Cultural Competence Training Plan

FY 12-13

Participants	Training Topic	Provided by	Instruction Design	Timeline		Evaluation
Clinical Staff Basic:	Various Specific Populations (knowledge training)	The Knowledge Center (TKC), Contractors	Varies- All staff are required to attend a minimum of 4 hours annually of cultural competence training annually	2012-2013	LGBTQ, Latino, African American, Asian/Pacific Islanders, Native American, Middle Eastern, Gender Responsiveness	Reaction Learning
	Consumer Culture – Adult/Older Adult (awareness training)	BHETA	Classroom- # of trainees			Reaction Learning
	Consumer Culture – Children, Youth, TAY (awareness training)	BHETA	Classroom- # of trainees			Reaction Learning
Clinical Staff Intensive	Cultural Competence Academy (knowledge and skills training)	BHETA	Classroom- five 8-hour training sessions- offered three times per year- 120 Trainees. Selected programs only	2012-2013		Reaction Effectiveness
Participants	Training Topic		Instruction Design	Timeline		Evaluation
Administrative and Management Staff:	System overview of CC Plan and the County's Policy and Requirements		Leadership Plus Quarterly Meetings Series Presentations	2012-2013		Learning Effectiveness
Participants	Training Topic		Instruction Design	Timeline		Evaluation
Clerical Staff:						
Participants	Training Topic		Instruction Design	Implementation Timeline		Evaluation

CRITERION 6

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

County Commitment to Growing A Multi-Cultural Workforce: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

CRITERION 6 – COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

County's Commitment to Growing A MultiCultural Workforce: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations

The county shall include the following in the CCPR:

A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education Training (WET) component. ***Rationale****: Will ensure continuity across the County Mental Health System.*

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category. . .

SUMMARY OF COMPLETE COUNT AND EXTRAPOLATED ESTIMATES: ALL SEGMENTS

				Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers)										
Mental Health Rehabilitation Specialist	25.0	1	7.8							
Case Manager/Service Coordinators	1.0	0	0.0							
Employment Services Staff	0.0	0	0.0							
Housing Services Staff	2.5	0	0.0							
Consumer Support Staff	0.0	0	0.0							
Family Member Support Staff	0.0	0	0.0							
Benefits/Eligibility Specialist	7.0	1	2.2							
Other *Unlicensed* MH Direct Service Staff	31.0	0	0.0							
Sub-total, A (County)	66.5	2	10.0	30.0	13.5	12.0	8.0	0.0	0.0	63.5

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11) White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Mental Health Rehabilitation Specialist	185.5	1	58.8							
Case Manager/Service Coordinators	55.8	1	17.3							
Employment Services Staff	20.7	1	6.4							
Housing Services Staff	15.7	0	0.0							
Consumer Support Staff	21.7	1	22.0							
Family Member Support Staff	30.5	1	30.0							
Benefits/Eligibility Specialist	6.0	1	1.9							
Other *Unlicensed* MH Direct Service Staff	61.4	1	19.0							
Sub-total, A (All Other)	397.3	7	155.4	128.8	93.9	52.2	14.3	1.1	10.3	300.4
Total, A (County & All Other)	463.7	9	165.4	158.8	107.4	64.2	22.3	1.1	10.3	363.9
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers)										
Psychiatrist, general	7.2	1	0.5							
Psychiatrist, child/adolescent	4.8	1	0.5							
Psychiatrist, geriatric	0.0	1	1.0							
Psychiatric or Family Nurse Practitioner	0.0	0	0.0							
Clinical Nurse Specialist	45.0	1	13.9							
Licensed Psychiatric Technician	3.0	0	0.0							

Licensed Clinical Psychologist	1.5	1	0.5							
Psychologist, registered intern (or waivered)	3.8	0	0.0							
Licensed Clinical Social Worker (LCSW)	15.0	1	4.6							
MSW, registered intern (or waivered)	2.5	0	0.0							
Marriage and Family Therapist (MFT)	15.8	1	4.9							
MFT registered intern (or waivered)	5.0	1	1.6							
Other *Licensed* MH Staff (direct service)	3.0	0	0.0							
Sub-total, B (County)	106.4	8	27.5	55.2	10.0	10.0	23.0	1.0	0.2	99.4
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Psychiatrist, general	48.3	1	2.0							
Psychiatrist, child/adolescent	6.5	1	1.0							
Psychiatrist, geriatric	0.1	1	1.0							
Psychiatric or Family Nurse Practitioner	0.7	1	3.0							
Clinical Nurse Specialist	23.8	1	7.4							
Licensed Psychiatric Technician	4.0	0	0.0							
Licensed Clinical Psychologist	50.9	1	8.9							
Psychologist, registered intern (or waivered)	3.0	0	0.0							
Licensed Clinical Social Worker (LCSW)	30.8	1	8.4							
MSW, registered intern (or waivered)	98.0	1	30.4							
Marriage and Family Therapist (MFT)	74.7	1	21.4							
MFT registered intern (or waivered)	350.0	1	109.1							
Other *Licensed* MH Staff (direct service)	8.5	0	0.0							
Sub-total, B (All Other)	699.3	10	192.6	351.2	99.4	39.6	33.3	2.9	31.1	557.5
Total, B (County & All Other)	805.7	18	220.1	406.5	109.4	49.6	56.3	3.9	31.3	656.9

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers)										
Physician	1.0	0	0.0							
Registered Nurse	1.0	0	0.0							
Licensed Vocational Nurse	18.0	1	5.6							
Physician Assistant	0.0	0	0.0							
Occupational Therapist	0.0	0	0.0							
Other Therapist (e.g., physical, recreation, art, dance)	5.0	0	0.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	6.0	0	0.0							
Sub-total, C (County)	31.0	1	5.6	13.0	2.0	2.0	8.0	0.0	0.0	25.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Physician	1.1	0	0.0							
Registered Nurse	26.1	1	8.1							
Licensed Vocational Nurse	25.4	1	7.9							
Physician Assistant	0.0	0	0.0							
Occupational Therapist	0.5	0	0.0							
Other Therapist (e.g., physical, recreation, art, dance)	9.9	1	4.6							
Other Health Care Staff (direct service, to include traditional cultural healers)	0.1	0	0.0							
Sub-total, C (All Other)	63.1	3	20.6	34.2	3.6	8.7	6.7	0.0	1.4	54.5
Total, C (County & All Other)	94.1	4	26.2	47.2	5.6	10.7	14.7	0.0	1.4	79.5

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers)										
CEO or manager above direct supervisor	23.0	0	0.0							
Supervising psychiatrist (or other physician)	5.0	1	1.0							
Licensed supervising clinician	9.0	1	2.8							
Other managers and supervisors	15.0	0	0.0							
Sub-total, D (County)	52.0	2	3.8	42.0	5.0	1.0	2.0	0.0	0.0	50.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
CEO or manager above direct supervisor	100.1	0	0.0							
Supervising psychiatrist (or other physician)	2.0	0	0.0							
Licensed supervising clinician	39.8	1	12.3							
Other managers and supervisors	49.9	1	15.5							
Sub-total, D (All Other)	191.8	2	27.8	124.6	24.4	6.6	16.6	0.0	3.9	176.1
Total, D (County & All Other)	243.8	4	31.6	166.6	29.4	7.6	18.6	0.0	3.9	226.1
E. Support Staff:										
County (employees, independent contractors, volunteers)										
Analysts, tech support, quality assurance	69.0	1	0.0							
Education, training, research	1.0	1	0.0							
Clerical, secretary, administrative assistants	104.0	1	0.0							
Other support staff (non-direct services)	12.0	0	0.0							
Sub-total , E (County)	186.0	3	0.0	89.0	29.0	18.0	46.0	0.0	0.0	182.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Analysts, tech support, quality assurance	15.0	1	4.7							
Education, training, research	7.7	0	0.0							
Clerical, secretary, administrative assistants	183.3	1	57.9							
Other support staff (non-direct services)	1.4	0	0.0							
Sub-total , E (All Other)	207.4	2	62.6	64.7	60.9	15.3	14.0	0.6	10.4	165.9
Total, E (County & All Other)	393.4	5	62.6	153.7	89.9	33.3	60.0	0.6	10.4	347.9

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E)**	441.9	16	46.9	229.2	59.5	43.0	87.0	1.0	0.2	419.9
***All Other (CBOs, CBO sub-contractors, network providers, and volunteers* (A+B+C+D+E)**	1558.8	24	459.0	703.5	282.1	122.4	84.9	4.6	57.1	1254.5
TOTAL COUNTY WORKFORCE (A+B+C+D+E)	2000.7	40	505.9	932.7	341.6	165.4	171.9	5.6	57.3	1674.4

Major Group and Positions				**Race/ethnicity** of individuals planned to be served -- Col. (11)						All indivi-duals (5)+(6)+ (7)+(8)+ (9)+(10)
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			43.9%	29.9%	13.1%	4.8%	0.6%	7.6%	100.0%
# of individuals being served				24,306	16,596	7,238	2,662	339	4,236	55,377

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience.

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? 1=Yes; 0=No	# additional clients or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	21.7	1	21.7
Family Member Support Staff	30.5	1	30.5
Other *Unlicensed* MH Direct Service Staff	0.0	1	10.0
Sub-total, A:	52.2	3	62.2
B. *Licensed* Mental Health Staff (direct service)	0.0	1	0.0
C. Other Health Care Staff (direct service)	0.0	0	0.0
D. Managerial and Supervisory	2.0	1	2.0
E. Support Staff (non-direct services)	0.0	0	0.0
GRAND TOTAL (A+B+C+D+E)	54.2	5	64.2

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

Language, other than English		Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)		(2)	(3)	(4)
1. Spanish	Direct Service Staff	375	245	620
	Others	179	0	179
2. Tagalog	Direct Service Staff	37	16	53
	Others	17	0	17
3. Vietnamese	Direct Service Staff	13	22	35
	Others	6	0	6
4. Arabic	Direct Service Staff	10	16	26
	Others	2	1	3
5. Russian	Direct Service Staff	9	4	13
	Others	1	0	1
6. Cambodian	Direct Service Staff	8	1	9
	Others	3	1	4
7. Sign	Direct Service Staff	13	2	15
	Others	11	2	13
8. Lao	Direct Service Staff	1	3	4
	Others	1	3	4
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	466	309	775
	Others	220	7	227

The WET Needs Assessment findings are the result of a comprehensive data collection process: 3 targeted surveys; 25 focus groups; 25 key informant interviews; 229 providers, community partners, consumer groups, educational institutions and county staff; as well as quantitative and qualitative information on current San Diego County mental health staffing patterns, hard-to-fill positions, additional staffing requirements, and current ethnic and language capacity.

A. Shortages by occupational category:

Three quarters of the County of San Diego's public mental health workforce is contracted staff employed by community-based organizations (CBO). The remainder of the workforce is distributed among the County, employing less than one quarter of the workforce (22%), and fee-for-service providers (FFS) (3%) (see Chart 1 Mental Health Workforce by Type).

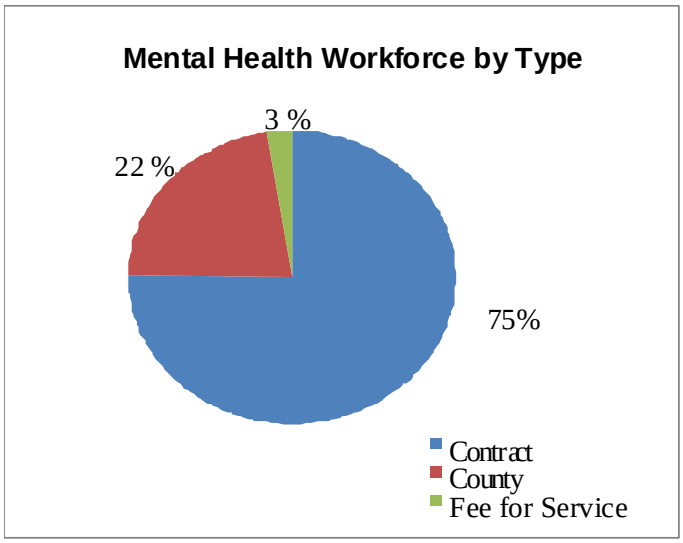


Chart 1 – Mental Health Workforce by Type

Workforce distribution figures reveal that the highest percentage of positions are in Licensed Mental Health Direct (39%), followed by Unlicensed Direct (24%), and Support Staff (20%) (see Chart 2, Workforce Position by Classification).

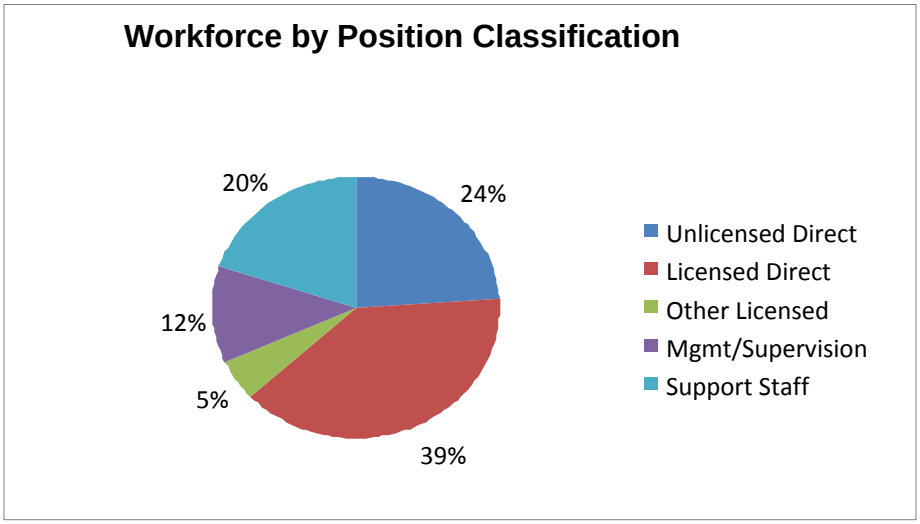


Chart 2 – Workforce Position by Classification

The County's WET Needs Assessment revealed that more than twice the number of unlicensed direct care mental health staff is needed as compared to licensed mental health staff. However, the number of hard to fill or hard to retain occupational categories is greater within the licensed category, and this is particularly true of contract agencies.

Hard to fill or retain unlicensed positions, in which substantial numbers of staff are needed, include: unlicensed rehabilitation specialists, case managers and consumer support staff. In terms of licensed staff, psychiatrists, nurses, social workers are needed. The number of needed staff indicated in the assessment exceeds the expectation for positions to be budgeted in the foreseeable future. Therefore, an assessment of annual staff replacements over the last two years was conducted to determine how many positions the County could expect to be available, given present levels of funding. According to this analysis, approximately 100 unlicensed positions and 50 licensed positions are estimated to become available. In our work detail actions involving career pathways, internships and financial incentives, we have aimed for providing training and assistance to provide enough persons to fill approximately half of these vacant positions. This is based on the assumption that this many positions would likely be available annually even with unforeseeable budget cuts and hiring freezes.

Quantitative data collection and additional analysis of workforce by position classification data also revealed the following about hard-to-fill positions:

- Particular Direct Service staff positions were more difficult to fill than others;
- Unlicensed Direct Staff positions remained vacant primarily as a result of both non-competitive salaries and the unique qualifications needed for these positions; whereas Licensed Direct Staff positions were difficult to fill due to noncompetitive salaries and requirements for bilingual staff, primarily Spanish;
- Qualified clinical supervisors were identified as hard-to-fill, especially professionals with LCSW or MFT licensure;

- Hospitals and clinics are struggling from the overall shortage of nurses available in the county;
- Several positions have been vacant for over a year, particularly in rural areas or positions requiring licensed bilingual capability;
- Intense competition exists in the community for bilingual professionals and bilingual clinical positions;
- Positions are difficult to fill because salaries remain below community standards.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

"Cultural Competency means identifying ways to connect regardless of ethnicity – it is being respectful and non-judgmental about a client's situation, limitations and condition." – Consumer Advocate

A common theme expressed repeatedly among focus group participants regarding the concept of cultural competence was *the ability to connect and to relate to consumers of diverse ethnicities and experiences, while maintaining an inclusive approach in service delivery*. A humanistic, consumer-driven and non-judgmental approach was emphasized in focus group discussions on issues of the relationship between the current diversity of the mental health workforce and the population it serves.

Both San Diego County's public mental health workforce and its target population receiving public mental health services are, in general, fairly diverse. Examining workforce by diversity, the public mental health workforce in San Diego County is 59% Caucasian, 19% Latino/Hispanic, 8% African Americans/Blacks, 9% Asian/Pacific Islanders, and 1% Native American; similarly examining consumers by ethnicity: 43% Caucasian, 30% Latino/Hispanic, 13% African Americans/Blacks, 5% Asian/Pacific Islanders, and 1% Native American.

While both groups may themselves be diverse, a comparison of their respective diversity reveals they diverge from each other in distinct ways. Chart 3, a side-by-side comparison, depicts these divergences. For example, overall, 41% of the workforce is ethnically and culturally diverse, whereas 57% of the population served is ethnically and culturally diverse. Examining the divergence within each race/ethnicity category we find Caucasians and Asians are overrepresented in the workforce[1], while Latinos and African Americans are underrepresented.

[1] *However, within the Asian component of the workforce, the vast majority is Japanese. Vietnamese, Cambodian, Hmong, Lao and Samoan are underrepresented.*

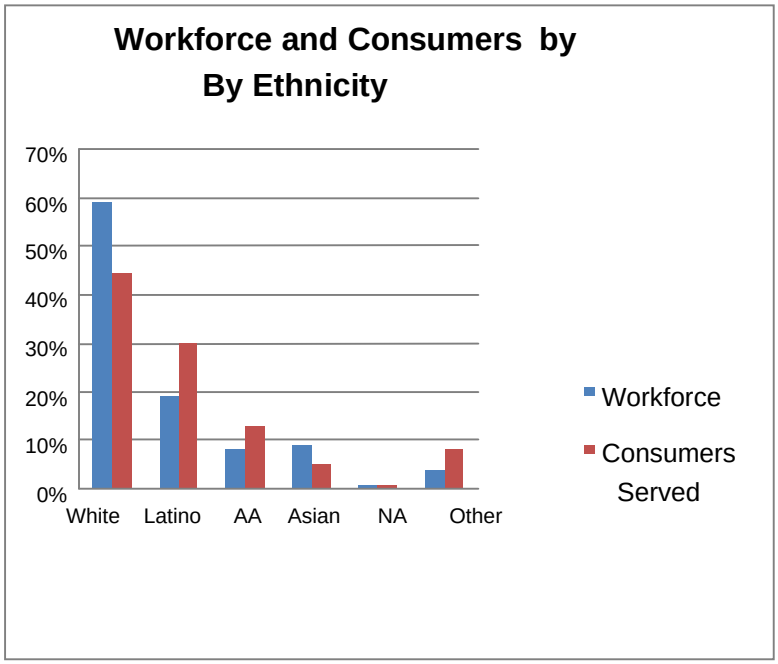


Chart 3 – Workforce and Consumers by Ethnicity

Note: Within the Asian component of the workforce, the vast majority are Japanese. Vietnamese, Cambodian, Hmong, Lao, and Samoan are under-represented.

As depicted in Chart 4, Workforce Diversity by Position reveals that Unlicensed Direct Staff and Support Staff are closest to the 56% diversity of those being served in the public mental health system at 51% and 57% respectively, while licensed, management/supervisory and other healthcare position classifications are significantly less representative of diversity of those being served.

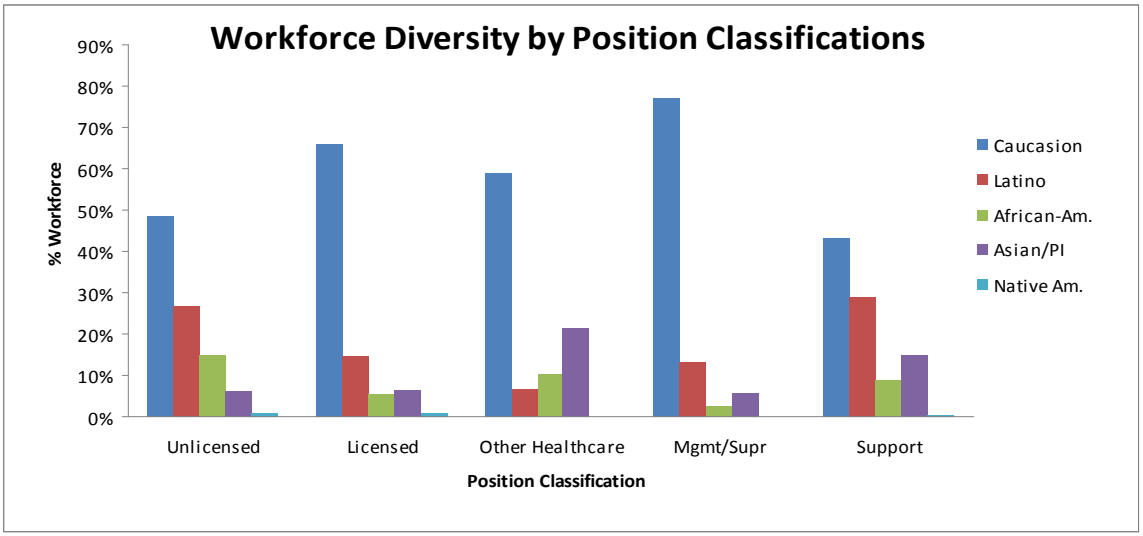


Chart 4 – Workforce Diversity by Position Classification

C: Positions designated for individuals with consumer and/or family member experience:

Consumers and family members offer a wealth of life experiences, cultural competencies and compassion, and understanding of the mental health system and related resources. They assist in linking consumers with services, provide useful information on navigating the mental healthcare system, and give much-needed encouragement and moral support to their peers. Currently, 82 people comprise 52.2 FTEs in specifically designated consumer/family positions in the public mental health workforce. These positions are primarily in Peer-to-Peer programs, Clubhouses and Full Service Partnership programs. Recognizing the importance of the voice of the consumer, there are currently Consumer Liaison staff assigned to each region with the goal to coordinate meaningful client partnerships to ensure a "consumer voice" in adult and older adult mental health services, in the area of policy, practice, program development and implementation as well as a consumer representative on all the mental health councils and boards.

Though the mental health workforce is only beginning to incorporate consumers and families, the benefits of their involvement are clear, and also essential to the implementation of a consumer and family-driven system. Equally important, consumers and family members have also diversified the workforce with their presence as 64% of consumer and family members are ethnically and culturally diverse as compared to 40% of non-identified consumer staff. Increasing the participation of consumer and family members in San Diego County's public mental health workforce helps to further two crucial WET intentions – increasing consumer and family member involvement as well as increasing the cultural competence and racial/ethnic diversity.

D. Language proficiency:

"As a bilingual staff person, I have a lot more responsibility for making sure that all the client's needs are met. I can't just send them to another agency for additional services because they don't have a bilingual worker available to help them."

- Hmong Provider Participant

The threshold languages for San Diego County are: (1) Spanish, (2) Vietnamese, (3) Tagalog, and (4) Arabic. In addition to these threshold languages, the following linguistic needs were identified by participants: Chaldean, Hmong, Cambodian, and Laotian. Reference was made to a growing immigrant population from East Africa, many of whom speak Somali and Swahili. All focus group participants and key informants expressed a need for more bilingual and bicultural mental health workers.

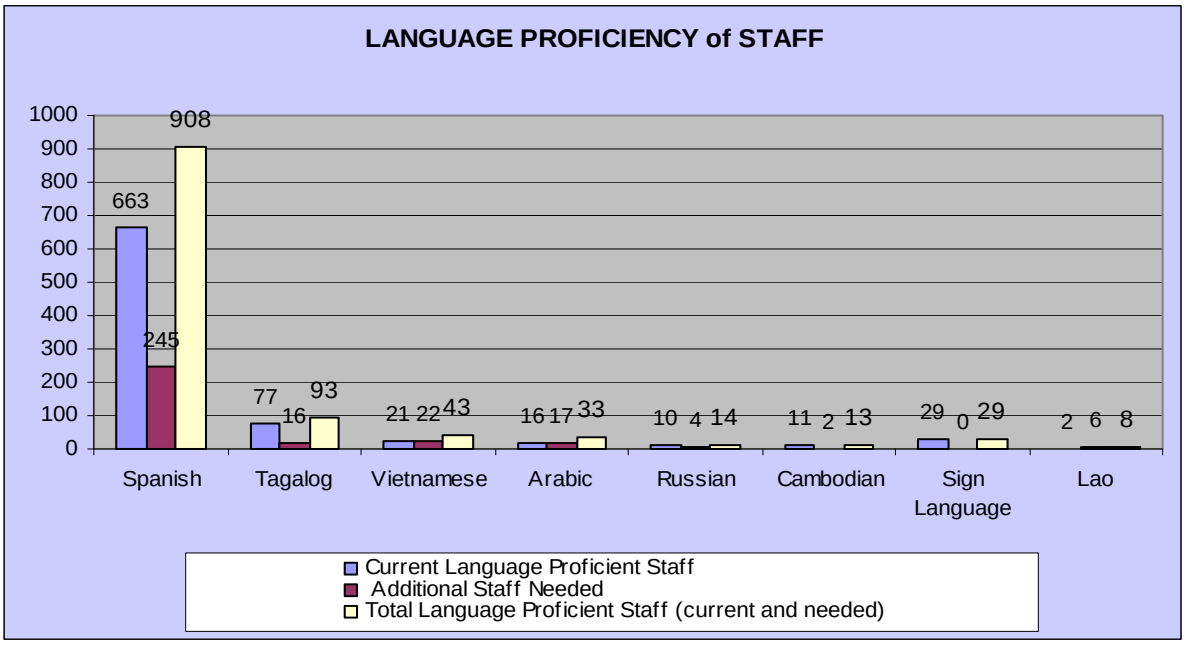


Chart 5 - Language Proficiency of Staff

Chart 5, Language Proficiency of Staff, illustrates staff language proficiency needs. Workforce qualitative data revealed that the requirement for bilingual staff was one of the top reasons for the continued vacancy of direct service staff positions. Spanish continues to be the most sought after language in the mental health workforce. Service providers must be bilingual, and preferably bicultural, in order to successfully meet the needs of Latinos in this region.

E. Other, miscellaneous:

To fully address cultural issues affecting access to public mental health services, San Diego County's public mental health workforce must also consider life stage. Each age group - children, Transitional Aged Youth (TAY), adult and older adult - presents with unique challenges and issues that require special knowledge, skills and competencies. Specific groups in this category include: (see Chart 6).

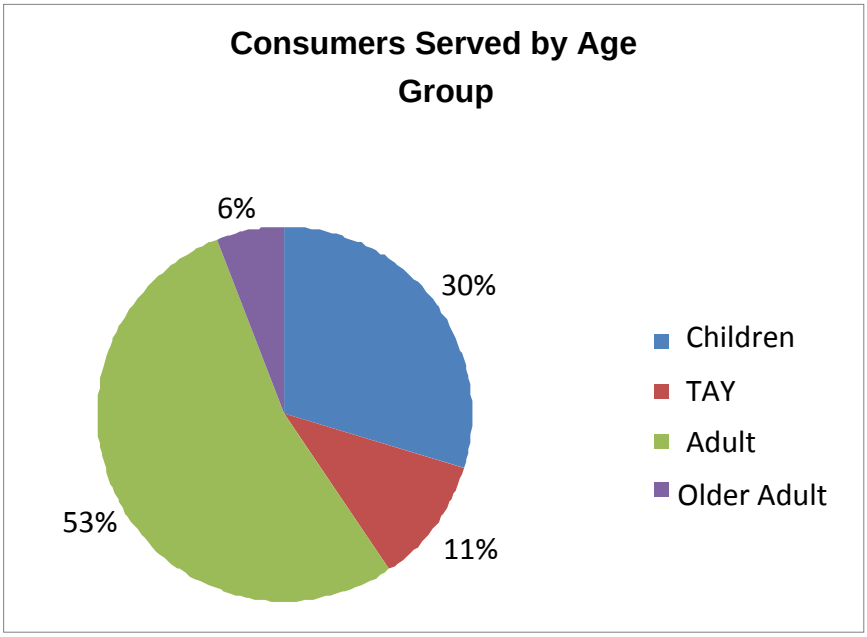
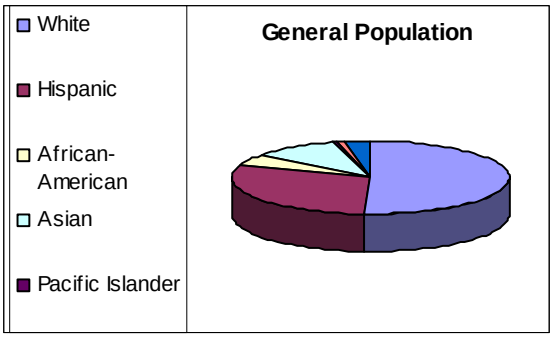


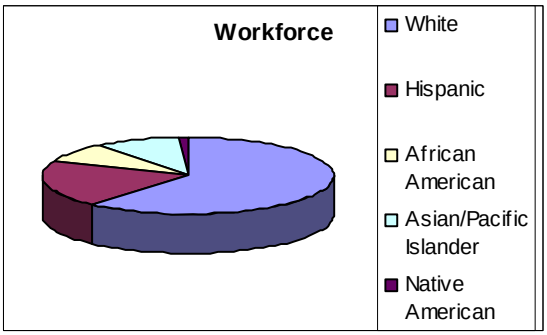
Chart 6 – Consumers Served By Age Group

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

Disparities by race/ethnicity

The WET Plan, above, contains a comparison of SDCMHS staffing with the race/ethnicities of its client population. (As discussed previously San Diego does its planning on the combined Medi-Cal and 200% of poverty data.) The differences between the general population and the Workforce profile echo these same differences, as can be seen in the pie charts below.) The WET Plan notes that Unlicensed Direct Staff and Support Staff are closest to the diversity of those being served, while licensed, management/supervisory and other healthcare positions classifications are significantly less representative of the diversity of those being served. This would seem to indicate a shortage of therapists, psychologists, and psychiatrists with bi-lingual skills needed by the mental health population.





Disparities by Position Classification

In addition to the disparities by Language Needs, there are also disparities by type of position classification-- 39% of the workforce are licensed mental health direct service positions, 24% are unlicensed direct service positions, and 20% of the staff fills support positions. Unlicensed staff include rehabilitation specialists, case managers, and consumer support staff. Based on an analysis of vacancies in the past two years, it is expected that twice as many unlicensed positions will open due to natural attrition as licensed positions.

- The reasons for vacancies among unlicensed staff were found to be a combination on non-competitive salaries and unique qualifications needed for the positions.
- Intense competition exists in the community for the limited number of bi-lingual professionals and bi-lingual clinicians. Salaries are below community standards.
- Qualified clinical supervisors were identified as hard-to-fill, especially professionals with LCSW or MFT licensure.
- The need to develop a more vigorous consumer voice was noted as essential to have an effective consumer and family-driven system.
- The need to have additional staff with clinical expertise appropriate for age groups with growing needs, such as the 0-5 population, TAY (a group poorly linked with services) and Older Adults.

C. If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

The County of San Diego did not receive cultural consultant technical assistance recommendations.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

Target Reached: Obtained a broad spectrum of stakeholder input on education and training needs:

- Built upon CSS and PEI planning processes which included over 950 adult and older adult client surveys in threshold languages (Spanish, Vietnamese, English and Tagalog) and 700 family member surveys, 60 stakeholder meetings, and ongoing input from age-based Care Councils.
- Aggregated information on workforce gaps from stakeholder groups

Target Reached: Developed a workforce needs assessment

- Contracted with San Diego State University Research Foundation Academy for Professional Excellence to lead effort and provide expert advice.
- Phase 1 –collected baseline information from a broad range of stakeholder and community members involved with the public mental health system. The efforts included 25 semi-structured focus groups; members of hard-to-reach communities were especially sought out for participation. Over 50 Key Informant interview were conducted who had in-depth experience with targeted key populations. Additional focused surveys were administered to a target group of 290 clients/family members, program managers, and direct mental health service providers, finally, existing County data was aggregated.
- Phase 2—completed data analysis comparing the ethnic and age composition of the San Diego population, the SDCMHS mental health population, and the workforce. Compiled baseline information about educational institutions in San Diego with programs geared toward mental health occupations from high schools to post-doctorate degrees. Conducted an in-depth training assessment survey of 721 County BHS staff regarding specific training needs. Also conducted additional Key Informant interviews with community partners with workforce development expertise.

Target Reached: Developed WET Needs Plan

- Community and stakeholder input on WET Needs Assessment gathered through System of Care Councils and contractor and County staff meetings
- WET Work Group which included subject matter experts from Key Informants, MHS staff, and stakeholder representatives, transformed Needs Assessment into programming recommendations**.**
- A Cross Threading Group, composed of stakeholders from all groups, but who would not financially benefit from any contracts, reviewed the recommendations and set priorities for funding. The recommendations were brought to three planning presentation around the County open to the mental health community and the public.

Target Reached: Mental Health Board approval and Submission to the State.

- Final input from Community meetings was incorporated into the Plan
- The WET Plan was submitted to the Mental Health Board and approved in April, 2009.
- The Plan was sent to the State DMH**.**

Target Reached: Program Procurement and Implementation

- Currently, the target populations reached include the current public mental health workforce through the behavioral health training component under Training and Technical Assistance. San Diego State University Foundation, Academy of Professional Excellence is the County's current contractor through BHETA to provide behavioral health training to current providers. Training topics are numerous, but always include cultural competency components. Additional targeted populations include consumers and family members.
- The County of San Diego implemented the Consumer/Family Academy with Early Implementation Activities funding under Training and Technical Assistance. Currently the Consumer Family Pathway has been incorporated into the Public Mental Health Pathways. The County contracts with Youth Family Roundtable, NAMI and Recovery Innovations of California (RICA) to provide targeted training and support to consumers and family members.
- The majority of WET programs are expected to be implemented in the next six months. To address the multicultural needs of our community, in each WET Request for Proposal (RFP) that the County of San Diego, Mental Health Administration released since the approval of the WET Plan, the proposer has been required to respond to the following:

Target Population

1.1. The contractor shall create culturally and linguistically appropriate, targeted approaches to ethnically and linguistically diverse populations based on community and public mental health workforce need. Potential populations may include, but are not limited to:

1.1.1. Latino population.

1.1.2. Asian/Pacific Islander population.

1.1.3. Lesbian, gay, bisexual, and transgender (LGBT) population.

1.1.4. Individuals in or recently out of the foster care system.

1.1.5. Other populations as defined by County staff, community and public mental health workforce need.

In reviewing each proposal received, the Source Selection Committee (SSC) evaluated how well the proposer responded to their plans for targeting each of the populations referenced above. Each program that the SSC recommended for award sufficiently addressed how they would target ethnically and linguistically diverse communities. Data will be compiled once all the WET programs are fully implemented.

E. Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

During the planning and implementation process, the County of San Diego has learned how valuable it is to expand beyond our traditional mental health partners. To ensure the successful development and implementation of WET programs, outreach included local schools and universities and workforce developers such as the San Diego Workforce Partnership and the Department of Rehabilitation. The SDCMHS worked closely with our community partners to ensure any prospective partners were aware of WET and their potential role along the educational/workforce pathway.

F. Identify county technical assistance needs.

Technical assistance would be helpful about successful programs in other counties and the techniques/processes used to recruit, train, and maintain a culturally diverse workforce. Are there particular strategies which have been successful for specific ethnic populations such as Latino, Vietnamese, Filipino, Arabic, African refugees, etc.

CRITERION 7

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

LANGUAGE CAPACITY

CRITERION 7 – LANGUAGE CAPACITY

LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff Capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

The SDCMHS had been seeking ways to develop the diversity of the systemwide workforce for a number of years, but the lack of available funding for incentives and training has been a serious limitation. The inclusion of Workforce Education and Training funding in the MHSA has enabled the County to move forward with some concrete steps grow the bilingual staff capacity of its workforce. To specifically address building bilingual staff capacity, the following programs have been developed, with the progress to date in implementation discussed:

Action #3 (WET Plan p.35+): Public Mental Health Credential/Certificate Pathway

"This credential/certificate will be part of an accredited institution, such as a community college, and will assist individuals with educational qualifications for current and future employment opportunities. Recruitment …would focus on specific shortages in the public mental health direct service areas as well as on the delivery of services to targeted population groups such as early childhood, youth, transition age youth, adult older adults, and linguistically and culturally diverse communities. Partnering with a community college has a decided advantage in that will create options for the credential/certificate to be matriculated into AA and/or BA programs to assist those with lower levels of education to move…into a career pathway continuum. In addition, when coupled with practicum and mentorship opportunities and/or scholarships or stipends, the credential/certificate pathway could serve to encourage participation from culturally diverse populations e.g. age, income, ethnicity and/or traditional healers."

Progress to Date: The Program was selected through a competitive procurement process called Request For Proposal (RFP) and the successful bidder was Health Sciences High and Middle College. Over 50% of the students' first language is not English and 75% of the school is other than white, including 45% Hispanic and 20% African American. Over 60% of the students that attend HSHMC live at or below the poverty line Consistent with the demographics of the school, 125 students in the next three years are expected to graduate with advanced educational experiences in mental health to represent the linguistic, ethnic, racial, and socioeconomic diversity found in the inner city of San Diego. The program is expected to start in November 2010.

Action #4 (WET Plan, p.40+): School-Based Pathways/Academy.

"In order to promote mental health careers to students, this action will create a partnership between the County of San Diego and San Diego County schools to implement a mental health component/track to existing established Health Care Pathways programs. The intended result is an increase in the number of high school students who choose to purse mental health careers. The schools that will be targeted will include those whose enrollments include a high number of students who are linguistically, culturally, and economically diverse. This partnership with the schools affords San Diego County the opportunity to increase the diversity of the mental health workforce, while also reducing the stigma associated with mental illness. Exposure to occupations will include those indicated as priority areas including both clinical and non-clinical direct positions as well as a focus on occupations that serve particular areas of need e.g. early childhood, transition age youth, adult, and older adult as well as cultural and linguistic diversity.

Progress to Date: The Program was RFP'd and the successful bidder was Health Sciences High and Middle College (HSHMC). HSHMC is proposing to provide a mental health pathway in their curriculum for 25 juniors and 25 seniors annually. These 50 students will also receive a stipend for completing an internship in the mental health field. As mentioned above, over 50% of the students' first language is not English and 75% of the school is other than white, including 45% Hispanic and 20% African American. Over 60% of the students that attend HSHMC live at or below the poverty line. Consistent with the demographics of the school, we expect that the students will graduate with advanced educational experiences in mental health to represent the linguistic, ethnic, racial, and socioeconomic diversity found in the inner city of San Diego. The program is expected to start in September, 2010.

Action #5 (WET Plan p. 42+) Nursing Partnership for Public Mental Health Professionals

"This program is targeted "to expand the capacity for developing additional public mental health professionals in nursing occupations that are most needed. Programming would be in coordination with existing nursing pathways at local institutions of higher education. The areas of nursing need are: Clinical Specialists, licensed Vocational Nurses, Registered Nurses, and Psychiatric Nurse Practitioners. Schools that will be targeted will include those whose enrollments include a high number of students that are linguistically, culturally, and economically diverse. ….Academic instruction will be coupled with practicum and mentorship opportunities with public mental health contractors or with the County of San Diego…. The objectives include increasing the skill levels and educational attainment of diverse culturally and linguistically diverse/representative groups and increasing the number of culturally and linguistically diverse individuals working in public mental health occupations."

Progress to Date: The Program was RFP'd and the successful bidder was California State University San Marcos School of Nursing. Their proposal indicates that courses and clinical scenarios will include patients of different races and ethnic groups. The target group for recruitment includes ethnically and linguistically diverse students, gay, lesbian, bisexual and transgender students, and students in underserved areas. In the 2008/2009 academic year, the percentage of minority students was 53%. Students are fluent in a variety of languages including: Cambodian, Farsi, French, German, Hebrew, Hindi, Italian, Japanese, Portuguese, Russian, Spanish, Tagalog, Vietnamese and American Sign Language. The faculty and staff are appreciative of the values, knowledge and differences that multicultural students bring to the educational experience. A focus on diversity, cultural sensitivity, and valuing differences is the hallmark of all the nursing programs at the CSUSM School of Nursing. Students will have the opportunity to have international experiences in Mexico, Vietnam and Africa. The nursing program is expected to produce a culturally sensitive, highly experienced and competent psychiatric/mental health advanced practice nurse. The program will start in September 2010.

Action #6 (WET Plan, p. 44) Community Psychiatry Fellowship

"This program is directed toward remedying the shortage of psychiatrists through partnering with a medical school to fund a position (s) with the intent of increasing family medicine/psychiatry fellows with a community psychiatry specialization. The program may target culturally and economically diverse populations."

Progress to Date: The County of San Diego is currently in contract negotiations with the University of California San Diego. This program will start in November, 2010.

Action #7 (WET Plan p 46) Child Psychiatry Fellowship

"This program is directed toward remedying the shortage of child psychiatrists through partnering with a medical school to fund a position (s) with the intent of increasing family medicine/psychiatry fellows with a community child psychiatry specialization. The program may target culturally and linguistically diverse populations."

Progress to Date: The County of San Diego is currently in contract negotiations with the University of California San Diego. This program will start in November, 2010.

Action #8 (WET Plan, p. 48), LCSW/MFT Residency/Intern

"This program is directed at increasing the presence of licensed students in San Diego. The County of San Diego will explore developing a partnership with established LCSW and MFT training programs to fund residency/internship slot(s) to offer students compensation in exchange for a commitment to practice in San Diego County's public mental health workforce. The program objectives include having students be fluent in threshold and critically needed languages and be affiliated with under-served or unserved communities including Latino, African-American, Vietnamese, Cambodian, Hmong, Lao, and Samoan and/or experiences or providing services to such communities."

Progress to Date: The Program was RFP'd and three bidders below were successful. The program will start in September, 2010.

San Diego State University-LEAD (MFT)- Of the 72 students enrolled in the SDSU MFT program at any one time, the vast majority of students continue to be from underrepresented groups in higher education who are ethnically diverse, often first generation college students, immigrants and from diverse sexual orientations. The student body reflects the local community, with about 70-80% people of color in the current cohort including both U.S. born first generation immigrants, as well as international students.

The ethnic composition of the graduating 2011 cohort of 24 students in the MFT program is typical of the cultural diversity of the classes: 42% Latino, 12.5% Asian/Filipino/Pacific Islander, 16.5% African American, 3% Native American and 22% European American (white). The percentage of ethnically diverse trainees is 78%, representing linguistic diversity. Over one-third of this cohort are native speakers of: Spanish, Cantonese, Mandarin, Taiwanese, Vietnamese, Korean, Japanese and Tagalog.

San Ysidro Health Center (SYHC)- SYHC has been continuously working toward culturally proficient service delivery, and will incorporate a cultural competency component within its LCSW Intern Training Program. Interns will be expected to utilize their own cultural understandings and experiences as well as skills taught via cultural diversity training. Interns will be expected to demonstrate cultural awareness and sensitivity to differences in gender, age, and disabilities. In addition, interns will learn to work past any differences between themselves and the patient, and utilize cultural nuances to establish rapport, improve the provider-patient relationship, and advance clinical effectiveness. Four interns will be placed and two are expected to be hired by San Ysidro at the end of their internship.

Alliant International University- In developing the application process for the MFT stipend, we will encourage students from different cultural and linguistic background to apply. The application form will include applicant's ethnic/cultural background and linguistic capacity. In application selection, preference will be given to students who are proficient in a second language, including sign language.

<u>Action #9 (WET Plan p.40): Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff.</u>

"This program is designed to aid in the recruitment and retention of license eligible and culturally, linguistically and/or ethnically diverse public mental health staff to work in both the County and contracting community-based organizations (CBOs). The WET Needs Assessment also revealed a number of positions in licensed and unlicensed direct services were deemed hard to fill, including bilingual clinical positions. The objectives of this program include: increasing the ethnic diversity of licensed professionals, increasing the number of employees from underserved backgrounds, and increasing the number of employees with critical linguistic proficiencies.

Financial incentives will be awarded on a competitive basis; criteria will include:

- *Fluency in threshold and critically needed languages e.g., Spanish, Vietnamese, Tagalog, Arabic, Chaldean, Hmong, Cambodian, Laotian, Somali and Swahili.*
- *Culturally underserved, unserved or underrepresented community affiliation e.g., Latino, African-American, Vietnamese, Cambodian, Hmong, Lao and Samoan and/or experience providing services to such community members.*
- *Focus on specific regions or particular cultural/language diversity focused positions (e.g. rural, non-English speaking, Native Americans, refugees/immigrant populations).*

Candidates will be selected from a pool of candidates who have submitted a complete application. In addition, the application process will include an interview that will, in part, be used to assess the candidate's capacity to complete any educational programming required by the designated position and/or their commitment to continuing employment in the public mental health field in San Diego County (i.e., a demonstrable longstanding family or community ties in San Diego and/or an interest in working within the County for the foreseeable future).

Application pools will be opened and reviewed on a semi-annual basis. In years in which no funding is awarded, funding will "roll over" for allocation in future years. Opportunities will be explored to leverage financial incentives and assistance funding through coordination and/or integration with federal, state, regional and educational financial incentive programs. Candidates may be eligible for the following financial incentives, depending on merit and/or need."

Recipients of the larger stipends, scholarships and/or loan assumptions will be contractually obligated to work for Mental Health Services or contracting CBLs after completing studies for a period of time equal to the period in which they received support, with a minimum commitment of two years. Those who do not meet their obligations will be required to reimburse the County for the full amount of assistance, plus interest.

Progress to Date: This program is under development, with an RFP expected to be issued in December, 2010 and an expected start date in July, 2011.

2. Updates from Mental Health Services Act (MHSA), Community Service and Support (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

WET PLAN--EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

Language, other than English		Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)		(2)	(3)	(4)
1. Spanish	Direct Service Staff	375	245	620
	Others	179	0	179
2. Tagalog	Direct Service Staff	37	16	53
	Others	17	0	17
3. Vietnamese	Direct Service Staff	13	22	35
	Others	6	0	6
4. Arabic	Direct Service Staff	10	16	26
	Others	2	1	3
5. Russian	Direct Service Staff	9	4	13
	Others	1	0	1
6. Cambodian	Direct Service Staff	8	1	9
	Others	3	1	4
7. Sign	Direct Service Staff	13	2	15
	Others	11	2	13
8. Lao	Direct Service Staff	1	3	4
	Others	1	3	4
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	466	309	775
	Others	220	7	227

San Diego's WET Plan is just getting underway. Most programs to increase bilingual staff have start dates beginning in September, 2010 and beyond, so there are no updates available.

In addition to WET Plan activities to grow bilingual staff, all CSS programs contain a requirement for staff to be able to provide services in languages appropriate for their target populations, and have, accordingly made efforts to hire bilingual staff to the maximum degree available. Several CSS Plans focus specifically on providing bilingual services to clients:

- The Council of Community Clinics Program focusing on primary health and mental health integration for Latinos in their communities through care provision in eleven community-based, primary care clinics. Five of the clinics utilize Promotoras to engage Latinos with diabetes and depression through interventions provided in Spanish.

- Chaldean Middle-Eastern Outpatient Services provides services to the recently immigrated Middle Eastern community in San Diego who have previously been unable to access mental health programs due to cultural and language barriers. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals. The Annual CSS Update Submission of 5/12/09 stated that 170 clients were served, with the expectation that 330 clients will be served in future years, as per Enhancement 4 (submitted to the State on 5/22/09).

- Cultural Language Specific Outpatient Services for Children and Youth include a Full Service Partnership (FSP) designed to address disparities and reduce stigma associated with mental health services and treatment for Latino and API populations. This Program with its cultural and language specific services provides mental health services to seriously emotionally disturbed (SED) Latino and Asian/Pacific Islander (API) children their families, utilizing a comprehensive approach that is community-based, client and family-focused and culturally competent. The Annual Update Submission 1 submitted on 5/12/09 indicated that 91 clients would be served; this target was increased to 157 and then to 249 in subsequent Enhancements. Expanded services include case management, treatment plans that address obesity and diabetes, co-occurring services, and additional outreach and education to targeted populations in the Southeast area.

3. Total annual dedicated resources for interpreter services.

	FY08-09		FY09-10	
	Adult	Children	Adult	Children
Interpreters Unlimited #522356	$440,537.15	$441,019.30	$565,469.04	$573,013.46
	$881,556.45		**$1,138,482.50**	
Deaf Community Services #517406	**$35,025.00**		**$59,478.30**	
Network Interpreters #517292	**$17,220.00**		**$7,040.00** (Partial- June '10 invoice not in)	
UBH Language Line	**$16,341.63** (Costs for CY09: Jan - Dec '09)		**Not yet available**	
Totals:	**$950,143.08**		**$1,205,000.80** (Partial*)	

* Data from Language Line and year-end Network Interpreters not yet available.

LANGUAGE CAPACITY

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

County Mental Health Services Cultural Competency Standards requires that provider programs develop staff's language competency for threshold languages. However, if program staff cannot meet the need for language assistance, then the program shall provide interpreter services. Policy #01-02-203 Interpreter Services: Access and Authorization establishes a process to provide free interpreter service for mental health clients with Limited English Proficiency (LEP). Selected interpreter services include:

- Interpreters Unlimited (for language interpreting)
- Deaf Community Services (deaf and hearing impaired)
- Network Interpreting Service (back-up when Deaf Community Services is not available).

Procedures and practices for meeting clients' language needs are laid out in the County of San Diego Organizational Provider Operations Handbook which is a contract attachment for all outpatient programs. The following requirements which serve as the basis for contractors' provision of interpreter services are included in the following excerpts of the Organizational Provider Handbook: (See Appendix, Criterion 1, pp.1.I.A.3-9 for a complete copy of the Cultural Competence Section.)

"Current Standards and Requirements"

Culturally Competent Clinical Practice Standards:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.
10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.

14) Staffs actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Cultural/Ethnicity Requirements:

Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers.

Language Requirements:

Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free language assistance services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the Center for Community Health Education and Advocacy are Mandated Key Points of Entry for all threshold languages. In addition the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish
  - o EPU
  - o All Outpatient and Case Management programs
- Vietnamese
  - o UPAC
- Tagalog
  - o UPAC
- Arabic
  - o East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Additional Program Standards

Programs will also be encouraged to do the following: …..

"2) If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process must be documented.

3) Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, assess community needs and what efforts the program is making to meet those needs. Topics that must be covered in the survey or focus group are:

- Regarding Language:
  - o Offers of providers who speak the client's language, or interpreter services
  - o Linguistic proficiency of staff providing services or of interpreter if one is used
  - o Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language
  - o Availability of written materials, including alternate formats in client's preferred language
- Regarding Cultural/Ethnicity:
  - o Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment
  - o Direct services staff's knowledge of culturally appropriate referral resources

o Direct services staff's familiarity with variant beliefs regarding mental illness
o Appropriateness of clinic environment
• Results shall include outcomes, findings, and plans for interventions as needed. …"

Staff competence - SDCBHS and the Cultural Competence Resource Team have identified the following methods that providers will be encouraged to implement for evaluating staff competence in cultural competence: 1) use of the California Brief Multicultural Competence Scale (CBMCS) or other standardized measure, 2) conducting a survey amongst their clients to determine if the program's clinical and administrative services are perceived as culturally competent, 3) conducting a survey amongst their clients to determine if the program's clinical and administrative services are perceived as linguistically competent. The CBMCS is available on line. Surveys can be developed independently or if providers prefer samples of surveys will be published in a new Cultural Competence handbook that is being drafted, and will be available soon.

1. *A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.*

   Note: *The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.*

The SDCMHS contracts with its Administrative Services Organization (ASO), UBH-OptumHealth to provide a 24 hour phone line with statewide toll-free access that has linguistic capability, including TDD. The phone number is 800-479-3339 and the TDD number is 619-641-6992. While the ACL is required to be available across the State toll free 24/7, it may not be available for some cell phone users. Accordingly, the ACL has established a local 619 number for such cell phone users. Although the regulations don't address cell phone usage, UBH and the County of San Diego are considering ways to have a toll free number for all cell phone users also.

In FY 08-09, the Access and Crisis Line handled an average of 7,213 calls per month--of those approximately 3% were calls conducted in Spanish, the second most commonly spoken language in the County. The Access and Crisis Line (ACL) is staffed by a highly trained staff, many of whom are clinicians. During the regular work day, there is at least one Spanish speaking staff member available to immediately handle problems and inquiries from Spanish callers. To the maximum degree possible, the OptumHealth management seeks out bilingual speakers with mental health knowledge to staff the ACL, finding themselves in competition with other County contractors for a comparatively small pool of persons both with mental health experience and bi-lingual in Vietnamese or Arabic. The Access and Crisis Line also contracts with the Language Line to provide immediate interpreter services as needed in threshold and non threshold languages.

2. *Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.*

San Diego County explored utilizing the Health Care Interpreter Network (HCIN) which is a cooperative of California hospitals and health care providers sharing trained healthcare interpreters through an automated video/voice call center system to provide video language conferencing. Through this system, videoconferencing devices and all forms of telephones throughout a hospital/healthcare system connect within seconds to an interpreter on the HCIN system. When a language isn't available from an interpreter at an HCIN hospital, the call connects automatically to a contracted telephonic language provider. The languages currently

offered are Spanish, Cantonese, Mandarin, Vietnamese, Lao, Mien, Cambodian, Hmong, Korean, Russian, Farsi, Armenian and Hindi. American Sign Language is also available on HCIN video stations.

HCIN is currently not being implemented for San Diego County because of the cost and because two of the four County's threshold languages (Tagalog and Arabic) are not available. Annual membership fees in HCIN are: $40,000 for public hospitals, $50,000 for populations with significant indigent/Medi-Cal service, $60,000 other community hospitals. In addition, installation costs are between $120,000 and $150,000 per site. Since State funding for services has been cut, the County's ability to add features has been drastically limited. However, San Diego County will continue seeking more affordable options for video interpreting services which can be shared with several hundred provider sites over a large geographical area.

3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.

SDCMHS Policy #01-02-203 (Interpreter Services: Access and Authorization) sets forth the protocol for implementing language access through the county's 24-hour phone line that has statewide toll-free access (the Access and Crisis Line). Providers must inform clients of their right to receive help from an interpreter and document the response to the offer. Upon request of the client, providers must arrange for language assistance. Providers can get linked with the Language Line provided by the ASO, if they do not have an in-house link to other interpreter services. The process used at the Access and Crisis Line to link a caller with its Language Line is as follows:

1. "Ask the caller to hold while you get an interpreter.
2. On the Avaya IP Agent Software, press Conference Hold to place the caller on hold
3. Dial 1-800-0874-9426. Press 1 for Spanish interpreters. Press 2 for all other languages.
4. UBH client ID 795254
   Organizational Name: United Behavioral Health, Crisis Line
   People Soft Code: 41270 1540 1815
5. Advise the interpreter:
   "Interpreter, this is the San Diego County Access and Crisis Line. I have a monolingual (language) caller on the line. I would like you to interpret directly. I will speak directly to the client and will start with our standard greeting. If you are ready, I will add the caller."
6. Add the Limited English speaker to the line and use the standard greeting.
7. At the closing as the caller: "Is there anything else I can assist you with today?" If no, state: "Please release the interpreter when you are ready."

4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

OptumHealth staff on the Access and Crisis Line go through four phases of training to learn how to maintain contact with a caller and establish rapport, provide support, intervention and referrals, and handle the documentation required. One to one coaching is provided to learn these skills and tasks. Trainees initially monitor calls and observe the process and then go on to progressively participate in the calls and eventually to handle calls independently while being monitored. The goal for mastery of the Language Line and TDD is to: 1) successfully determine that the caller required an interpreter; 2) connect the caller to the Language Line; 3) conference in the caller; 4) successfully complete the call. Trainees are required to have five successes

before being allowed to handle such calls alone. However, at all times, clinical supervision is readily available, should staff experience a problem.

Individual providers are expected to train their staff on connecting with the Access and Crisis Line to receive quick language assistance for a caller or drop-in visitor with limited English proficiency.

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.

In the Quick Guide to Mental Health Services for Adult, Older Adults, and Children, distributed to all new consumers, there is a section that states:

"San Diego's Mental Health Plan Provides:

- Services in your preferred language or free interpreter services
- Providers with cultural/language specialties
- Culturally appropriate assessments and treatments
- Information in other languages and alternate formats for the visually and hearing impaired"

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, and Arabic and is available at all organizational provider locations and through Behavioral Health Services Administration. (See copies in the Appendix, Criterion 7, pp. 7.II.B.1-30.)

In addition, the County provides a Guide to Medi-Cal Mental Health Services in San Diego, a booklet about the mental health services that San Diego County offers and about the Medi-Cal Service Plan. The booklet is available in English, Spanish, Tagalog, Vietnamese, and Arabic. There is a section in the beginning of the booklet that states,

"If you feel you have a mental health problem, you may contact the San Diego Mental Health Plan Access and Crisis Line directly at (800)479-3339. This is a toll-free number that is available 24 hours a day, seven days a week. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language."

Additionally, all SDCMHS programs are required to have a copy of the sign below posted in their waiting rooms in threshold languages:

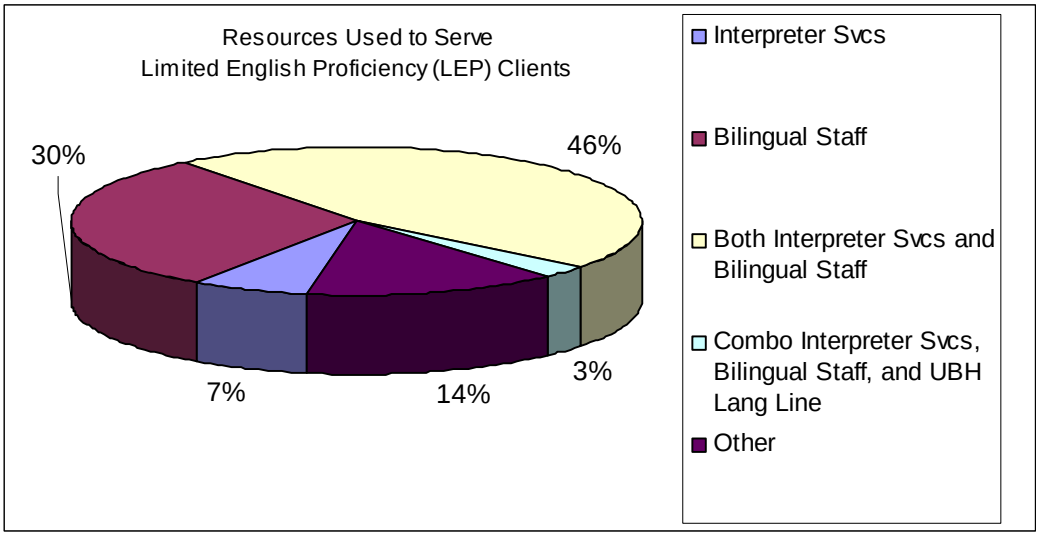
C Evidence that the county /agency accommodate persons who have LEP by using bilingual staff or interpreter services.

Appendix, Criterion 7, pp. 7.II.C.1-23 has examples of client records and services provided by county contractors in Spanish, Arabic, and Vietnamese.

1. Share lessons learned around providing accommodations to persons who have LEP and have needed interpreter services or who use bilingual staff.

During the months of August and September 2010, 80 Adult Mental Health Providers and 30 Children's Mental Health Providers participated in discussions about providing services to clients with Limited English Proficiency at Regional Meetings.

96% of providers who completed a survey have provided services to clients with Limited English Proficiency. The pie chart below indicates what types of services were utilized:



The following lessons learned were shared in the discussion:

- More bilingual staff are needed on site. Higher salaries for bilingual staff are needed for higher retention.
- When using Interpreter Unlimited (the free service available through the SDCMHS), it would be easier to have a way of scheduling electronically rather than through phone calls and faxing.
- Therapists need to be patient – the process of recovery tends to be slower for non-English speaking client than with English-speaking clients. Similarly, there is an impact on the therapy process (i.e. with an interpreter, 60 minutes is spent with the client, but 30 minutes is spent for interpretation)
- It is helpful to have a pre and post session meeting with the interpreter.
- It would also be helpful to have a system in place to provide an evaluation of each interpreter service session.
- It's important to train clinicians how to utilize interpreters – and likewise train interpreters about mental health services.

- It's better to use a professional interpreter rather than a family member to translate. Translators should be neutral and someone the client does not know personally.
- Clear instructions should be given to LEP clients so they know what to discuss with the clinician before a session.
- Families with LEP may not initially understand what psycho-therapy is, so it needs to be explained to help them be more receptive to services.

SDCMHS is looking into ways to address the lessons learned to improve our services to clients with LEP.

D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

SDCMHS had identified the following historical challenges and lessons learned for:

- Dedicating adequate funds to provide needed level of interpreter services at a time when there are many conflicting priorities.
- Staff need to reflect the target population, but scarcity of qualified personnel have limited access to language appropriate services.
- Staff retention is influenced by lack of resources to compensate at market rate for bilingual staff.
- Direct service programs need continuing monitoring to ensure that they are not overly relying on interpreter services rather than directly hiring bilingual staff.

E. Identify county technical assistance needs.

- SDCMHS would find it helpful to have technical assistance on county programs which are successfully reaching out to clients with limited English proficiency. It would be useful to know strategies to engage clients, the amount of time it took for engagement to occur, and lessons their staffs learned in putting together a successful program.
- San Diego is among the counties with the highest immigrant influx each year and is interested in learning how other counties nimbly respond to the changing needs of new immigrant groups.

LANGUAGE CAPACITY

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

Note: *The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.*

The county shall include the following in the CCPR:

A. Evidence of availability of interpreter (e.g., poster/bulletins) and/or bilingual staff for the languages spoken by community.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

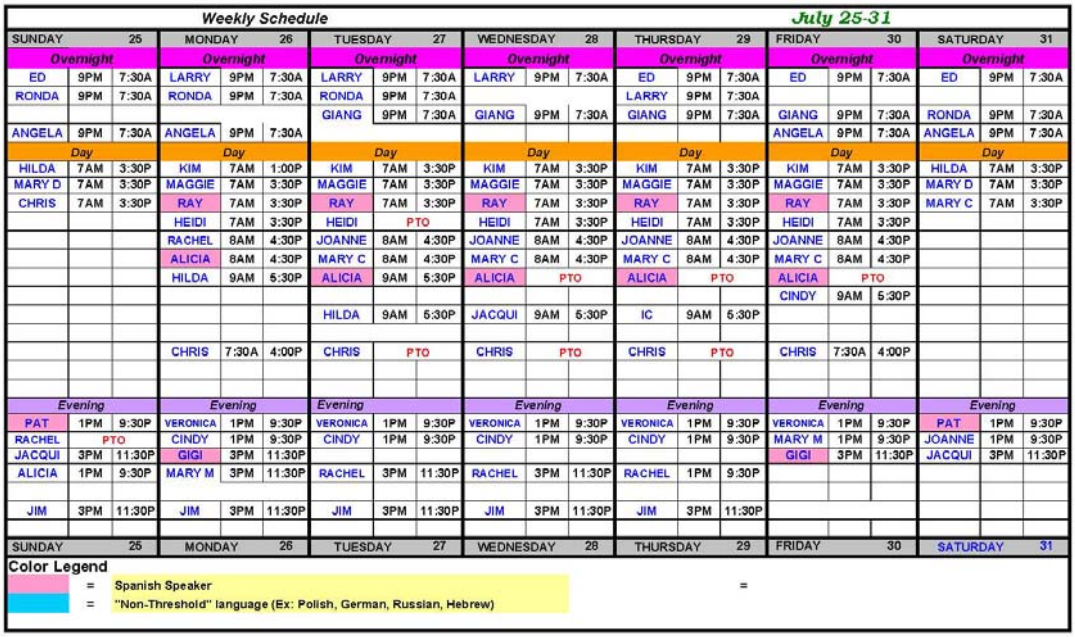
San Diego Mental Health Services has provided services to persons with Limited English Proficiency through the usage of interpreter services A comparison of interpreter services for the last five fiscal years can be seen below, where services increased almost by 200% from a total for adults and children in FY 04-05 of 3,362 hours to 9,742 in FY 08-09:

LANGUAGE	ADULTS & OLDER ADULTS					CHILDREN				
	04-05	05-06	06-07	07-08	08-09	04-05	05-06	06-07	07-08	08-09
Albanian		1	2	1						
Amharik	20	4	12	4	10				2	2
Arabic	331	283	344	314	429		3	19	12	6
Brazilian Portuguese								1		
Bulgarian										1
Cambodian	1	98	179	503	982	5	15	24	74	74
Cantonese		6			11		1			5
Chaldean	20	6	4	1	6	1	29			
Croatian			7	12	3					
Dari					6					
Farsi	14	23	25	34	78	2		8	2	6
French			7							
Japanese	30	39	6		3					
Korean			6	2			1	1	18	
Kurdi	7	2	1	13	28				4	1
Laotian	49	94	134	331	493	28	58	99	91	37
Mandarin	12		8	9	24	2			1	15
Nuer						5	18		1	
Oromo								1		
Polish	13	15	9	13	6					
Russian	48	50	62	83	80	1	14		1	
Sign Language										1
Somalian	11	52	30	19	47	13	4	6	25	10
Spanish	349	342	287	403	717	2128	3780	4474	4691	5332
Swahili						2				
Tagalog	25	25	68	75	53		1	74	47	18
Tegrinyan			4							
Thai	15		25	28	23				3	13
Turkish	7			1	1			1		
Urdu			5							
Vietnamese	63	328	498	768	1040	160	124	240	242	181
GRAND TOTAL	**1015**	**1368**	**1723**	**2614**	**4040**	**2347**	**4048**	**4948**	**5214**	**5702**

Client use of interpreter services is documented in the monthly invoices which the SDCMHS receives from Interpreters Unlimited. See a sample Invoice in the Appendix, Criterion 7, pp. 7.III.B.1. Client use of interpreter services is also documented in each client's clinical record. See a sampling of such documentation below:

C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

The 24 hour Access and Crisis Line has Spanish coverage (the County's second most used language) during regular day operating hours. See a sample of their weekly schedule below:



Weekly Schedule — *July 25-31*

SUNDAY 25			MONDAY 26			TUESDAY 27			WEDNESDAY 28			THURSDAY 29			FRIDAY 30			SATURDAY 31		
Overnight			*Overnight*			*Overnight*			*Overnight*			*Overnight*			*Overnight*			*Overnight*		
ED	9PM	7:30A	LARRY	9PM	7:30A	LARRY	9PM	7:30A	LARRY	9PM	7:30A	ED	9PM	7:30A	ED	9PM	7:30A	ED	9PM	7:30A
RONDA	9PM	7:30A	RONDA	9PM	7:30A	RONDA	9PM	7:30A				LARRY	9PM	7:30A						
						GIANG	9PM	7:30A	GIANG	9PM	7:30A	GIANG	9PM	7:30A	GIANG	9PM	7:30A	RONDA	9PM	7:30A
ANGELA	9PM	7:30A	ANGELA	9PM	7:30A										ANGELA	9PM	7:30A	ANGELA	9PM	7:30A
Day			*Day*			*Day*			*Day*			*Day*			*Day*			*Day*		
HILDA	7AM	3:30P	KIM	7AM	1:00P	KIM	7AM	3:30P	KIM	7AM	3:30P	KIM	7AM	3:30P	KIM	7AM	3:30P	HILDA	7AM	3:30P
MARY D	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MARY D	7AM	3:30P
CHRIS	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	MARY C	7AM	3:30P
			HEIDI	7AM	3:30P	HEIDI	PTO		HEIDI	7AM	3:30P	HEIDI	7AM	3:30P	HEIDI	7AM	3:30P			
			RACHEL	8AM	4:30P	JOANNE	8AM	4:30P	JOANNE	8AM	4:30P	JOANNE	8AM	4:30P	JOANNE	8AM	4:30P			
			ALICIA	8AM	4:30P	MARY C	8AM	4:30P	MARY C	8AM	4:30P	MARY C	8AM	4:30P	MARY C	8AM	4:30P			
			HILDA	9AM	5:30P	ALICIA	9AM	5:30P	ALICIA	PTO		ALICIA	PTO		ALICIA	PTO				
															CINDY	9AM	5:30P			
						HILDA	9AM	5:30P	JACQUI	9AM	6:30P	IC	9AM	6:30P						
			CHRIS	7:30A	4:00P	CHRIS	PTO		CHRIS	PTO		CHRIS	PTO		CHRIS	7:30A	4:00P			
Evening			*Evening*			*Evening*			*Evening*			*Evening*			*Evening*			*Evening*		
PAT	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	PAT	1PM	9:30P
RACHEL	PTO		CINDY	1PM	9:30P	CINDY	1PM	9:30P	CINDY	1PM	9:30P	CINDY	1PM	9:30P	MARY M	1PM	9:30P	JOANNE	1PM	9:30P
JACQUI	3PM	11:30P	GIGI	3PM	11:30P										GIGI	3PM	11:30P	JACQUI	3PM	11:30P
ALICIA	1PM	9:30P	MARY M	3PM	11:30P	RACHEL	3PM	11:30P	RACHEL	3PM	11:30P	RACHEL	1PM	9:30P						
JIM	3PM	11:30P	JIM	3PM	11:30P	JIM	3PM	11:30P	JIM	3PM	11:30P	JIM	3PM	11:30P						
SUNDAY 25			MONDAY 26			TUESDAY 27			WEDNESDAY 28			THURSDAY 29			FRIDAY 30			SATURDAY 31		

Color Legend

= Spanish Speaker

= "Non-Threshold" language (Ex: Polish, German, Russian, Hebrew)

In view of the shortage, and in some cases scarcity, of clinicians and other direct service staff who are bi-lingual in threshold languages, especially Vietnamese and Arabic, the SDCMHS does not currently require providers to submit evidence of in-house staff linguistic proficiency during regular day operating hours. However, an overall picture of staff language proficiency for FY 09-10 has been included in the Appendix, Criterion 7, pp. 7.III.C.3-5. The majority of services are conducted during business hours, so it is possible to use the report as a gross indicator of bi-lingual availability.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

SDCMHS has a contract in place with Interpreter's Unlimited to provide interpreter services. Their contract Statement of Work includes the following statements about ensuring interpreters are trained and monitored for language competence:

- "Contractor shall ensure all personnel assigned to provide language interpretive services meet all applicable licensing, applicable certification, training and/or professional criteria during all periods of services provision. Interpreters shall demonstrate proficiency in English and non-English language; possess knowledge of specialized terms used in the mental health field; and have clear understanding of interpreting ethics and practice."
- "Contractor shall maintain files of language interpretation professional criteria of all assigned personnel, including contracted and subcontracted personnel. Contractor will maintain and make available, personnel files of aforementioned professional criteria upon request of the County. "

<u>Evidence of Interpreter Services Training by the Language Line (used by the SDCMHS 24/7 Access and Crisis Line</u>

"Recruiting, Training & Quality Processes at Language Line Services" (LLS)

Language Line Services has implemented the highest standards for its interpreters in recruiting, training, and interpreter certification in the country. It has also specifically trained its interpreters on the Standards for Practice from the National Council on Interpreting in Health Care. The details of Language Line Services' recruiting assessment, training, and certification program are described below.

1. Interpreter Recruiting Process

To ensure and maintain premium language interpretation services, Language Line Services (LLS) deploys a comprehensive testing and evaluation process to retain the best interpreters. All interpreters are tested and accredited by Language Line Services' highly qualified and experienced raters to provide our customers with the most accurate and professional telephonic interpreting services in the industry.

Resumes are received from a wide variety of sources from all over the country. Language Line Services is represented at every major professional interpretation conference in the country, including the annual conferences of National Association of Judiciary Interpreters and Translators (NAJIT), American Translators' Association (ATA), and other interpreters associations.

LLS closely monitors all interpreter training developments nationwide and keeps a database of schools, organizations, websites, and agencies for recruiting purposes. LLS recruiting department initiates and maintains relationships with those recruiting sources that have proven to be most productive. It also conducts extensive Internet research on language-related sites and frequently identifies candidates over the Internet. Furthermore, LLS gives presentations and workshops on the unique nature of telephonic interpreting at different interpretation training programs to attract the best candidates with related training background.

LLS also has an extensive referral program through its staff interpreters and advertises in major newspapers and publications targeted towards certain ethnic groups and language professionals.

Once candidates are identified, they are screened, tested and accredited through the following multi-step process:

1) Preliminary screening through an over-the-phone interview to verify skills indicated on the candidate's resume.
2) An oral proficiency test for both English and the target language--The proficiency test evaluates key areas, such as the speaker's comprehension ability, grammar, breadth of vocabulary, pronunciation and enunciation, and overall presentation. If proficiency is at the Advanced or Superior level, the candidate is scheduled for the next requisite test.
3) Interpreter Skills Assessment (ISA), which is a Language Line Services proprietary test, developed with over 20 years' experience as the leader of the industry—The ISA is a rigorous, criterion-referenced integrative test designed to specifically evaluate a candidate's interpretation skills. It is bi-directional—from English into a target language and from the target language into English--and is conducted in the consecutive mode, mirroring in content, as well as format, the interpretation scenarios LLS interpreters handle, including calls from the medical settings. The ISA is evaluated by both an objective scoring method and a subjective assessment, with an emphasis on the objective scores…

2. Interpreter Training and Certification:

A. Orientation Processes

Language Line Services has a two-week new hire orientation process for its interpreters. During the orientation, new hires undergo basic training, job shadowing with senior interpreters, service observation and feedback, and Question-and-Answer Sessions. Specifically, the following will be covered:

- The basics of interpretation
- The roles of an interpreter and the Interpreter Code of Ethics. Confidentiality is emphasized and each interpreter is required to sign a Non-Disclosure Agreement, which is witnessed and kept on file; interpreters are also trained on HIPAA and GLB Act requirements on confidentiality
- Methods and Procedures of call handling, Personnel Guide, and other administrative matters
- Interpreting skills and customer service skills. In addition to training on fundamental interpreting skills, such as note-taking and memory-retention, the trainer also teaches new-hires the required skills for providing exceptional customer service and the highest degree of professionalism
- Review of industry standards; interpreters listen to scenarios of simulated typical interpretation calls. LLS has developed standards for each industry based on formal feedback gathered from customer surveys and Voice of the Customer programs, as well as from participation in professional

organizations such as the American Translators Association, National Council on Interpreting in Health Care, and ASTM.

New hires also job shadow senior interpreters and discuss their learning with the Orientation Trainer. In addition to learning and practicing typical industry scenarios and terminology, new-hires are provided an internally developed, 575-page At-A-Glance Industry-Specific Glossaries as a job aid to assist them on calls.

The new-hire orientation also contains an evaluation component. Only those who meet the predetermined criteria, as demonstrated through role-playing and other exercises, will be deemed qualified to take calls as active interpreters.

Every new hire is assigned to a Senior Language Specialist (SLS) who will then provide hands-on, one-on-one training. The SLSs are senior interpreters with extensive education and experience in the interpretation field. Each SLS works with a group of 15-30 interpreters. The SLS will not only share his or her skills and experience with the new hire, but will also observe the new hire during calls and provide immediate feedback and coaching. Usually feedback is given to new hires within the same day of the observation, no later than the next business day, to help new hires build up skills and confidence, identify improvement areas, and offer guidance.

B. Training, Continuing Education and Development for the Interpreters:

The Interpreter Training Department at LLS provides on-going training in the following areas: Finance, Insurance, Court, Medical, Technical Terminology, 911, Stress Reduction, and Customer Service Skills.

Many of the training curricula are developed in collaboration with external training/teaching experts and with input from customers. The Advanced Medical Training for healthcare interpreters was developed internally by medical professionals who are also interpreters for LLS, as well as interpreters with experience as trainers and healthcare interpreters; this training is used to supplement the more basic Medical Interpreter Training that LLS co-developed with the Cross Cultural Health Care Program, a leading medical interpreting training organization, located in Seattle, Washington (www.xculture.org).

All of LLS' training programs provide both training material and instructed training sessions. The training contents are pertinent to real call scenarios that the interpreters deal with on the job. During the training sessions, the interpreters actively participate in role-playing and discuss terminology in their working languages. Training sessions are taught by the instructors who have been involved in the training development because of their expertise in the industry; they are also senior interpreters.

LLS also trains the interpreters on healthcare interpreting requirement based on the document of Standards of Practice issued by the National Council on Interpreting in Health Care.

C. Interpreter Certification:

Because of a lack of standard certifications at the national level, and in response to clients' needs and the demand for interpreters with proven competence in interpreting for specific industries, LLS has become a pioneer in the certification field. In the late 1990's, LLS developed its own internal certification program with the collaboration and validation of external experts. All certification tests have been validated by a psychometrician and external experts, including LLS clients from the industry. The tests have been designed to represent the breadth of calls that LLS interpreters encounter during their work, as well as the wealth of terminology that exists within each industry and the industry-specific protocols. Each test is an oral over-the-phone exam that is administered on a one-to-one basis, and in the consecutive mode. In addition to their work experience, test candidates are provided with test preparation materials prior to each testing round.

To be deemed Certified in any given industry, an interpreter must have met the following criteria:

- Passed the initial Interpreter Skills Assessment Test
- Undergone the New Hire Orientation
- Completed Industry-specific Training
- Passed the Industry-specific Certification Test
- Maintained satisfactory service observation ratings

- Received positive customer feedback based on data from the Voice of the Customer Program.

All six criteria are carefully reviewed once an interpreter has passed the Certification Test, and industry-specific certifications are issued only to those interpreters who have demonstrated a consistent quality of performance and level of expertise worthy of certification, as measured by the aforementioned standards.

This multifaceted model is based on the Company's belief that no single form of evaluation can provide a complete assessment of an interpreter's proficiency. Our model examines diverse domains to measure interpreter competency and utilizes both skills assessments and performance-based evaluation criteria for certification. The aforementioned six components include evaluations of interpreters' job performance through service observation and customer feedback, training participation, as well as skills assessment through testing. This makes Language Line Services' certification distinctly different from any other certification program. LLS has filed for a patent for this comprehensive certification program and the patent is pending.

Currently, LLS' Medial Certification Test, Language Proficiency Test, and Interpreter Skills Assessment, along with several LLS training programs, are all available to LLS customers through Language Line University.

3. Quality Monitoring

LLS has a department dedicated to managing our quality monitoring process, the Quality Assurance Department. A group of Senior Language Specialists (SLS) are trained to not only conduct quality monitoring but also to provide constructive feedback. A Senior Language Specialist usually works with 15-30 interpreters and all SLSs are selected for their top-notch language and interpretation skills and are trained to provide in-language observation and feedback.

Additionally, the Interpreter Training Department works closely with the Quality Assurance Department in identifying training needs and developing training programs at a higher level. Many Senior Language Specialists are also trainers, who can train the interpreters on their teams. Observation information is also frequently taken into consideration in interpreter communications, e.g., the monthly interpreter newsletter covers issues and challenges identified through monitoring, without using real client or interpreter names to maintain confidentiality.

Interpreters are evaluated according to their performance level, which is determined by both service observation data as well as customer feedback. Performance is reviewed and measured according to the identified needs of the individual interpreter. The interpreter manager will evaluate the performance of an interpreter at any time if there is a concern raised by either external or internal customers. A formal written appraisal is conducted once a year."

LANGUAGE CAPACITY

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health systems at all points of contact.

The county shall include the following in the CCPR:

A. Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

Policy #01-02-202 -- Provision of Culturally and Linguistically Appropriate Services (copy in Appendix, Criterion 7, pp. 7.IV.A.1-4) includes practices and procedures for referring and otherwise linking clients, who do not meet the threshold language criteria (e.g. LEP clients) to culturally and linguistically appropriate services.

See also the SDCMHS Organizational Provider Operations Handbook section on Cultural Competence quoted previously in Criterion 1 (Appendix, Criterion 1, pp. 1.I.A.3-9) for procedures in place to serve, link and refer, as necessary, clients to culturally and linguistically appropriate services.

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

See answer above in Section IV. A.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:

1. *Prohibiting the expectation that family members provide interpreter services;*
2. *A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services;*
3. *Minor children should not be used as interpreters.*

Policy #01-02-202 (Appendix, Criterion 7, pp. 7.IV.A.1-4): Based on the Civil Rights Act of 1964 (42 U.S.C., Section 2000(d), 45 C.F.R., Park 80), when a need is determined, the County of San Diego's Health and Human Services Agency, Mental Health Services ensures that a process is in place for accommodating and referring clients to available cultural and/or linguistic services. That process is established through Policy #01-02-202 (Provision of Culturally and Linguistically Appropriate Services) which also requires that all mental health services providers have language assistance available to persons with Limited English Proficiency (LEP) to ensure them equal access to programs and services.

The policy states that all LEP persons, speaking threshold or non-threshold languages, shall be informed in a language they understand that they have a right to free oral interpretation assistance. It also states that:

- There is no expectation that family members provide interpreter services.
- A consumer/client may choose to use a family member or friend as an interpreter, after being informed of the availability of free interpreter services.
- Other than in extenuating circumstances, minors (under the age of 18) may not be used as interpreters even if the applicant/beneficiary requests to do so, although at the applicant's/beneficiary's request the minor may be present in addition to the county provided interpreter. Temporary extenuating circumstances may include using a minor child to determine the appropriate language needs of the adult so that an appropriate interpreter or bilingual staff person could be called or in order for the county to ask the client to wait while the county obtains the interpreter service.

LANGUAGE CAPACITY

V. Required translated documents, forms, signage, and client informing materials.

The county shall have the following available for review during the compliance visit:

A. Culturally and linguistically appropriate written information for threshold languages, including

the following, at minimum:

1. *Member service handbook or brochure;*
2. *General correspondence;*
3. *Beneficiary problem, resolution, grievance, and fair hearing materials;*
4. *Beneficiary satisfaction surveys;*
5. *Informed Consent for Medication form;*
6. *Confidentiality and Release of Information form;*
7. *Service orientation for clients;*
8. *Mental health education materials; and*
9. *Evidence of appropriately distributed and utilized translated materials.*

Samples of the materials listed in items 1-8 above will be available at the next compliance visit. The availability of materials at provider locations is monitored by the Quality Improvement Unit through Site Reviews and other reports. Attached is an annual report on Provider Requests for Materials in Threshold Languages prepared and distributed by the SDCMHS in FY 09-10 as evidence of provider requests for and distribution of many of these materials.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

The SDCMHS will have documented evidence in the clinical chart at the time of the next compliance review. Please see the Appendix, Criterion 7, pp. 7.II.C.1-23 for a sample of such case notes.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

The County of San Diego used the mandated State satisfaction survey in FY 08-09 and 09-10 for all of its outpatient providers. Translations were provided by the State, eliminating the need for County translation. However the State does not provide an Arabic translation. Since there has been some change in the questions over the years and since the State has only been able to get their approved survey to the counties two or three weeks before the mandated survey dates, SDCMHS has not been able to have it translated into Arabic, printed, and distributed to providers in time for the mandated survey dates. The State is in the process of piloting another form of beneficiary survey which may influence the County's process in the future to obtain information on individual provider satisfaction results. If the SDCMHS decides to continue with the original State Survey, the County will have the form translated into Arabic.

Summary reports of results of the Youth and Adult Satisfaction Surveys are in the Appendix, Criterion 7, pp. 7.V.C.1-25.

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

Currently the SDCMH uses a translation service to provide needed translations and updates of translated documents. Materials received from the translation service are reviewed by SDCMHS clinicians for accuracy prior to distribution. Due to a lack of resources (money, staff, staff time) the SDCMHS does not currently have the ability to assemble a group to conduct field testing of every revised document in each language.

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

The text difficulty of all documents is tested through the WORD 2003 grading system, and wording is modified to the maximum degree possible to keep materials at a 6th grade reading level.

CRITERION 8

COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

ADAPTATION OF SERVICES

CRITERION 8– ADAPTATION OF SERVICES

ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs.

The county shall include the following in the CCPR:

A. List and describe the county's/agency's client-driven/operated recovery and wellness programs.

SDCMHS has the following client driven recovery and wellness programs:

Adult/Older Adult Program Advisory Groups

Program Advisory Groups (PAGs) are composed of at least 51% mental health consumers and/or family members who are integrated in outpatient programs as a required program component that provides feedback and ideas to mental health programs about recovery services in the program. PAG meetings follow an agenda, attendance is recorded and minutes are taken. Guidelines for implementing PAGs across the Adult/Older Adult Mental Health System of Care have been instituted in an effort to standardize this important vehicle for soliciting feedback to improve programs.

Client-Operated Clubhouse Programs

The Adult/Older Adult System of Care currently supports the operation of thirteen (13) Client-Operated Clubhouse Programs located throughout the different geographic Regions of San Diego County. The Clubhouse programs provide social and vocational rehabilitation, as well as recovery and vocational services that assist members to increase their social rehabilitation skills, reduce social isolation, increase independent functioning, and increase and improve education and employment. Additional services include Mental Health Services Act (MHSA) Enhancement and Expansion for Employment activities. Many different tools and techniques are employed to help clients learn living and interpersonal skills and to provide opportunities for advancement. In six of the Clubhouses, an SSI Advocate is also available to provide assistance and support to non General Relief mental health consumers seeking to apply for and secure SSA/SSI benefits.

Warm Line Service

The "Warm Line" is an essential non-crisis peer telephone support service for persons recovering from mental illness who are living in the San Diego County community. The peer-run service assists callers by providing support, understanding, information, and referrals. The "Warm Line" is operated 7 hours a day, in the late afternoons/evenings each week by persons who are succeeding in managing their mental health symptoms and who are supporting others in their recovery efforts. The goals of the Warm Line program include promoting stability and reducing problematic situations that may lead to a crisis. Callers are provided information and referrals to appropriate community resources and non-crisis intervention services including offering coping techniques in order to assist callers to improve their self-care skills.

Older Adult Elder Multicultural Access and Support Services (EMASS) program

The EMASS program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County. EMASS is an age and culturally/linguistically appropriate, peer-based, outreach and engagement model to support prevention activities and increase access to care. It utilizes "Promotoras" or Community Health Workers (CHW) as liaisons between their communities and health, human service and social organizations to bring information to their communities. The CHW and/or peer community liaison functions as an advocate, educator, mentor, outreach worker, role model, cultural broker, and translator.

Client-Operated Peer Support Services
This client-operated peer support services program provides countywide peer education, peer advocacy, peer mentoring, and peer support of client-identified goals (including work) with referrals to relevant support agencies, and skill development classes to adults and older adults with serious mental illness. This program's services focus on rehabilitation and recovery of adults and older adults who meet eligibility criteria, utilizing Biopsychosocial rehabilitation (BPSR) principles, in accordance with County Mental Health Services policy in the areas of dual diagnosis/co-occurring disorders (COD) and cultural competence.

Client Liaison Services
The Client Liaison Services program supports BPSR and Recovery principles and practices by developing and coordinating continuous efforts toward increasing consumer involvement, participation and partnership in the development and implementation of existing and evolving Adult/Older Adult Mental Health Services (AOAMHS) policies, practices and programs in order to ensure consumer needs are accommodated.

Roadmap-to-Recovery
Roadmap-to-Recovery (R2R) groups provide a non-threatening and non-judgmental learning environment led by trained Peer Facilitators who discuss how clients can best interact and learn to advocate for themselves with their treatment team. Through discussion, the R2R groups aim to educate about self-management and treatment of their illnesses from the experiences of others. The R2R program utilizes collections of drawings made by clients to facilitate discussion that provides reassurance and support by the sharing of participants' own stories.

Mobility Management in North San Diego County
Mobility Management in North San Diego County is an upcoming MHSA Innovations project designed to reduce barriers and increase mobility and transportation options for adults and older adults with mental illness in North San Diego County. This project will use several strategies to increase access to transportation including, but not limited to, developing a Travel Buddy System, establishing a Transportation Coordinator position, and implementing a Peer "Ride Share" Program. This project will provide an opportunity to learn if increased information and support improves access to mental health services and if these strategies increase quality of life and mobility of underserved consumers.

Peer and Family Engagement Project
A project under development, the Peer and Family Engagement Project (PFEP) proposes to employ integrated teams of TAY, adult, older adult and family support specialists to engage clients and families prior to their first visit to a mental health clinic and during their treatment at the San Diego County Psychiatric Hospital's (SDCPH) Emergency Psychiatric Unit (EPU). PFEP teams will be integrated into provider teams at outpatient clinics and the EPU with a focus on outreach, engagement, referral and linkage. This project will provide an opportunity to learn whether early peer and family engagement results in improved access and utilization of mental health services for clients who receive initial engagement at the EPU and whether there will be greater client retention in mental health services. In addition, PFEP will help to determine if a systematic effort to involve family members and peers contributes to better outcomes in the EPU and improved long-term recovery outcomes for clients.

Family and Adult Peer Support Line
This Prevention and Early Intervention (PEI) program provides specialized culturally and developmentally appropriate behavioral health service for adults, older adults, and their families who live in communities with a high concentration of ethnic minorities in order to promote their social and emotional wellness. This non-crisis, confidential, anonymous, stigma-free, toll-free, peer support line provides countywide telephone counseling services, support and referrals to adults and older adults, including those who may struggle with alcohol or drugs.

Peer Employment Training Program
The Peer Employment Training (PET) program is a 75 hour training provided for people with lived experience of recovery from mental health or co-occurring mental health and substance abuse challenges to work in the service system as a Peer Support Specialist. The training focuses on ways to use personal experience and skills to inspire hope in the lives of other individuals receiving services. Prerequisites include: High School Diploma or GED, Completion of WRAP (Wellness Recovery Action Plan) and attending the PET orientation.

Family Education Services
This program provides education and support that is built around goals and tools to help family members and friends understand, cope with and respond to issues that arise due to a family member's mental illness. The program utilizes a series of educational classes presented by family members using an established family education curriculum that has a goal of promoting the natural supports of family and friends with a focus on recovery and resiliency.

Family Youth Roundtable
The Family/Youth Liaison (FYL), a client/family operated organization, has the primary duty of coordinating and advancing family, youth, and professional partnership in Children's Mental Health Services (CMHS). The Family is defined as a caregiver of a child/youth who has or is currently receiving services from a public child/family-serving agency. Youth is defined as a person age 0 to 25 that has received or is currently receiving services from a public child/family-serving agency.

The Family and Youth Roundtable Executive Director also collaborates with CMHS administrative staff to ensure family and youth voices and values are incorporated into MHSA service development and implementation plans, as well as in the overall County of San Diego CMHS service delivery system.

The goal of the Roundtable contract is to advance and coordinate family/youth partnership in new and existing CMHS programs. Advancement shall be demonstrated by:

- Reinforced policies and procedures on family/youth professional partnership through participation in County of San Diego Contract Officer Technical Representative (COTR) Team reviews.
- Increased family/youth representation in policy, practice, evaluation, program development, and implementation planning.

1. *Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.*

SDCHMS offers the following alternatives to accommodate individual preferences:

The Language Line provides interpreter services designed to help individuals understand a program/service delivery without altering, modifying or changing the intent of a message. This free service is available to clients with limited English proficiency (LEP) in threshold and non-threshold languages, if it is needed for the delivery of specialty mental health services. American Sign Language (ASL) interpretation is also available.

The Warm Line service has two Spanish speaking staff for some shifts and utilizes the Language Line for clients who request to speak with peers in their preferred language.

The newly established Adult Peer Support line has Spanish speaking staff for Spanish-language callers, and plans the use of the Language Line for most non-English speakers. This program also is working

collaboratively with providers to remotely utilize an Asian - American peer for a more culturally attuned response to Asian/Pacific Islanders who use this service.

Program Advisory Groups in the South Region are conducted in English and Spanish to accommodate the high Spanish-speaking population.

Roadmap-to-Recovery (R2R) groups are facilitated in languages that reflect the population it serves. Clients can choose which R2R group they wish to attend.

Staffing and personnel in each SDCMHS program patterns are also to reflect the populations served to the maximum degree possible. Clients also have the right to change providers if they wish.

The Family Youth Roundtable contract Statement of Work states that "Contractor shall liaison with organizations targeting unserved and underserved communities. Those ethnic communities may include Asian/Pacific Islander, Hispanic, African or African/American, Native American or Deaf."

2. *Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.*

The following adult mental health programs are client-driven/client operated.

Friendship Clubhouse
The MHSA Gap analysis data indicates that in the Central region, Adult and TAY African-Americans and Latinos may be groups that are unserved. Friendship Clubhouse improves both access and services by providing culturally appropriate services for these unserved populations.

Eastwind Clubhouse
The Eastwind Clubhouse located in San Diego County's Central region provides culturally competent services to Asian/Pacific Islanders in three Asian languages: Vietnamese; Hmong and Cambodian.

Older Adult Elder Multicultural Access and Support Services (EMASS) program
The EMASS program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County.

Casa del Sol Clubhouse
This client-operated clubhouse program creates an environment that is welcoming to the culturally and ethnically diverse population of the region, with a special focus on Adult, Older Adult and TAY Latino population in that area. All program staff are bilingual Spanish, so monolingual Spanish speaking members can be accommodated.

Roadmap-to-Recovery (R2R)
Where appropriate and facilitator availability permits, a minimum of one R2R group in each clinic is conducted in a threshold language (other than English) that serves the majority of clients in that clinic or HHSA region.

Warm Line Service
The Warm Line service has bilingual Spanish peer specialists for some shifts.

Family and Adult Peer Support Line
This program utilizes a bilingual Spanish family member staff. This program will also offer family support in selected Asian/Pacific Islander languages.

ADAPTATION OF SERVICES

II. Responsiveness of Mental Health Services

The county shall include the following in the CCPR:

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

SDCMHS has been primarily occupied in the last decade with building up the spectrum of services available to foster recovery, while seeking to meet the age-specific and geographical needs of mental health consumers. A Provider Directory listing linguistic and specialty services is available to the public upon request and a copy is kept in each program's waiting room for clients who wish to see if there is someone more linguistically/culturally appropriate to meet their service preference. Policy and Procedure 01-02-203 requires contractors and the County to meet the language preferences of clients to the maximum degree possible. This list is provided to clients upon request. The Provider Directory lists the cultural specialties of San Diego's organizational providers. (Please see the Appendix, Criterion 8, pp. 8.II.A.1-103 for a complete copy of the list.)

Because the penetration rate for Asians and Pacific Islanders has traditionally been low, SDCMHS has increased efforts to decrease this disparity. The Children's System of Care has implemented the CARE outpatient program using MHSA funding which targets Asians and Pacific Islanders. It is anticipated that the WET Plan's educational initiatives will contribute to building a workforce that is bilingual and bicultural in order to meet the needs of San Diego's threshold populations and other ethnic groups. Additionally, SDCMHS has contracted for over 20 years with the Union of Pan Asian Communities to provide services to the Asian and Pacific Islander populations.

As mentioned in Criterion 3 of this report, SDCMHS has set up 40 programs through Community Services and Support funding to address gaps in services for under-served and unserved populations. Please see the CSS program listing, with target populations served in the Appendix, Criterion 3, pp. 3.III.B.IV.1-19.

The County has started a Spirituality Workgroup to develop bridges to religious & spiritual groups with the hope of providing alternatives for clients living in the community who may be more comfortable with faith based, non-traditional providers. This program is in its infancy, with the first meeting in FY2009-10.

The Access and Crisis Line can also connect clients who wish to see a FFS provider with a number of specific language capabilities; however there continues to be a shortage of staff with capabilities in Asian and African languages.

As discussed previously, contractors are bound by the requirements in the Organizational Providers Operations Manual to provide clients with language appropriate services. The County provides free interpreter services, last year spending about $1million to achieve this access. The three most commonly requested languages for adult clients were Vietnamese, Cambodian, and Spanish for a total of about 2,700 hours. Bearing out the scarcity of bilingual Spanish clinicians and the success of the school-based program in reaching out to Hispanic clients, families of child and youth clients used over 5300 hours of interpreter services. Please see Criterion 7, page 14**,** for a report on usage of interpreter services both by provider and by language for FY2008-09.

While SDCMHS contractors have bilingual staff on programs, the significant expenditure for interpreter services bears out the need for SDCMHS to become more innovative and planful about recruiting staff with bilingual capability.

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

In the Quick Guide to Mental Health Services for Adult, Older Adults, and Children there is a section that states:

> "San Diego's Mental Health Plan Provides:
>
> - Services in your preferred language or free interpreter services
> - Providers with cultural/language specialties
> - Culturally appropriate assessments and treatments
> - Information in other languages and alternate formats for the visually and hearing impaired"

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, and Arabic and is available at all organizational provider locations and through Behavioral Health Services administration. A copy is provided in the Appendix, Criterion 8, pp. 7.II.B.1-30.

In addition, the County provides a Guide to Medi-Cal Mental Health Services that is a booklet that includes information about the mental health services that San Diego County offers and how to get the services. The booklet is available in English, Spanish, Tagalog, Vietnamese, and Arabic. There is a section in the very beginning of the booklet that states,

> "If you feel you have a mental health problem, you may contact the San Diego Mental Health Plan Access and Crisis Line directly at (800)479-3339. This is a toll-free number that is available 24 hours a day, seven days a week. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language."

C. Counties have policies, procedures and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services (Outreach requirements as per Section 1810.310, 1A and 2B, Title 9).

*(Counties may include **a.)** Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services, or **b.)** Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)*

SDCMHS has the following policies, procedures and practices in place for informing Medi-Cal beneficiaries of available services under consolidation of specialty mental health services:

In order to inform all Medi-Cal beneficiaries of available services under consideration of specialty mental health services, the County of San Diego Mental Health Services has in place Policy #01-04-210 (Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services) that ensures that all threshold language-speaking clients and clients needing information in alternate formats receive information in writing or in an appropriate manner to their special need to assist them to access Specialty Mental Health Services.

The SDCMHS widely distributes its "Quick Guide to Mental Health Services" in English and the four other threshold languages to inform clients of what mental health services are and how they can be accessed. Additionally, the County has made an effort to provide community information and education through a number of types of media. The Ethnic Services Coordinator provided a series of radio broadcast interviews in Spanish over the last two years as well as writing a regularly appearing series of articles discussing mental health issues in the Salud magazine (a Spanish/English publication). As part of the PEI programming, in FY 10-11, the SDCMHS will be putting out a fotonovela about mental health issues; over 40,000 copies will be distributed and two major Spanish language newspapers have agreed to carry the fotonovela as a serial. The fotonovela will also contain information on how to obtain mental health services.

As part of the process of setting priorities for the uses of MHSA funding, SDCMHS conducted extensive outreach activities to all cultural and linguistic groups through focus groups, community forums, regional meetings, over 60 stakeholders meetings, surveys, meetings with community commissions, client and family liaison agencies, etc. to try to ensure that the needs of all were heard and recorded.

In addition, below are examples of evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs from Monthly Status Reports (MSRs):

Adult/Older Adult Mental Health Services MSRs:

The **Breaking Down Barriers (BDB)** program performs outreach and engagement activities with multiple agencies, community groups, client and family member organizations and other stakeholders in selected communities to increase education and access to mental health services

for persons from un-served and under-served, culturally-diverse populations. The program utilizes community liaisons to coordinate and facilitate meetings and presentations and to educate cultural brokers who can share the acquired knowledge in their respective communities. Activities include outreach in health and wellness fairs at the City Heights Farmer's Market, in African American communities, at the Carlsbad Health and Wellness Expo, at the Somali Independence Day Celebration, at the Neighborhood Council's 1st Annual Community Love Day, and many others.

The Union for Pan Asian Communities (UPAC) biopsychosocial rehabilitation (BPSR) center participated in community outreach in the Green Lantern community festival on August 27, 2010 to outreach to the Vietnamese community. UPAC BPSR will also be participating in the Fil-Am Fest which is a Filipino-American health and community fair. The event will take place on October 2, 2010, in National City, CA. In addition, UPAC is scheduled to be interviewed by Vietnamese TV to inquire about depression and PTSD in the Vietnamese community.

In FY09-10 the **Chaldean Middle-Eastern Social Services (CMSS)** hosted a Hunger coalition meeting, met with several resettlement agencies regarding the refugee crisis and conducted a community outreach forum. CMSS also hosted a two day event with Iraqi Embassy in Washington to assist refugees regarding receiving their retirement from Iraq as well as completion of other documents. CMSS regularly participates in refugee forums.

Survivors of Torture International (SURVIVORS) ongoing outreach activities have been extensive, from attending ice cream socials to presenting to international delegates. Most notable in FY09-10 are: presentations on how to identify unaccompanied minors as torture survivors to national management staff of Southwest Key, a national nonprofit operating innovative youth justice programs, safe shelters for immigrant children, college prep and alternative schools and workforce services; participation as panelist on a "Violence Towards the Individual" roundtable at UCSD; meeting with the U.S. Census Bureau to commit to do outreach with undercounted populations; meeting with federal representatives of the U.S. Department of State and Department of Health and Human Services as well as East County stakeholders to discuss issues related to refugee influx.

The **Maria Sardiñas Center (MSC)** regularly attended the Chula Vistas Community Collaborative Meetings in order to inform other providers of their enhanced services. The MSC Transition Age Youth (TAY) program continues to offer short workshops for clients offering topics on time management, risk taking, and living sober. In addition, on 1/27/10 MSC hosted a SAMSHA grant kick off meeting where the newly enhanced physical health integration services were presented. Then on 6/25/10, MSC's Program Director presented to the San Diego MFT Educator Consortium on the "Recovery Model in Action"

The **Casa del Sol (CDS)** Food Commodities and Feeding America distributions attract many community members, often those with little means who are looking for community resources. The food activities are a source of outreach within the general community for consumers of mental health services.

The **Douglas Young Clinic (DYC)** outreaches weekly to Operation Samahan, a medical clinic, which serves many Filipinos. In these visits, DYC staff address the availability of cultural and linguistic services at their program for persons meeting specialty mental health services criteria.

In February 2010, **Heritage Clinic** reached out to culturally diverse populations through discussing services with Temple Adat Shalom in Poway. In March, 2010, Heritage Clinic provided outreach to the Asian community at the Chinese Service Center, where staff presented about Heritage Clinic services to more than 50 Asian older adults.

Specific examples of outreach to Latino and African-American populations provided by **Neighborhood House/Project Enable** are participation/presentations: at the San Diego Latino Film Festival in 3/20/10; at the African American Advisory Committee Meeting in 9/16/10; and at the Head Start Health Fair in 9/17/10.

Children's Mental Health Services MSRs

Evidence of outreach by the Family Youth Roundtable (FYRT**)**

- During FY 09-10, the Family Youth Roundtable (FYRT) hosted a total of 19 events in the Central, East, South, North Central and north county regions. These events had the purpose of introducing family/youth sector to partnership with public systems.

Examples of different outreach activities:

- **Outreach to High School students:** Outreaching to Garfield and San Diego High School students was completed via a FYRT staff person that approached students as they were heading to and leaving school for the day. The staff person distributed FYRT informational brochures and briefly mentioned the purpose of FYRT and how getting involved with FYRT could benefit the students. San Diego High school and Garfield high schools were chosen was because many students there had been transferred to these two schools due to behavioral disorders and/or involvement with the Juvenile Justice system. Outreach to these students included: African American students, Latino students, Asian/Pacific Islander students and Caucasian students.

- **Outreach in community clinics:** Outreaching to Oceanview Women, Infants and Children (WIC) office and the Oceanview Community Clinic was completed via an outreach staff person that approached families who were waiting to be seen for an appointment. These families were also invited to attend an upcoming Family Youth Council meeting; outreach staff shared that even if they could attend not in-person because of childcare or transportation issues, they could still call in from home using a toll-free dial in number. The racial and ethnic makeup of the families in these clinics was predominantly Latino American and African American.

- **Outreach to youth**: Youth was outreached at the Barrio Logan Youth Center and on the Metropolitan Transit system; an FYRT outreach staff approached these youth and introduced themselves and ask if they could have a moment of their time to tell them a bit about FYRT. Outreach staff asked the youth if they have had involvement with a public serving system, briefly defining the various public serving systems. The ethnic and racial makeup of these youth varied quite greatly, but included: African American youth, Latino youth, Asian/Pacific Islander youth and Caucasian youth.

- **Outreach to Community Based Organizations**: FYRT provides further outreach by attending monthly standing meetings including San Diego Domestic Violence Steering Committee, The Children's Mental Health System of Care Council. FYRT also

participates with different organizations at different events, for example, FYRT had resource boots at the Family Day in the Park, the Not to be Forgotten rally, the San Ysidro Health Center's 2009 Adolescent Health Conference and Lincoln High School's Community Health Fair. Additionally, the FYRT meets with representatives of Community Based Organizations such as the Jackie Robinson Young Men's Club of America (YMCA) to discuss ways to partner with the County of San Diego and FYRT in order to ensure that the youth involved with the YMCA are aware of the current mental health services, supports and opportunities for involvement.

- Outreach via the internet: Using their website; www.fyrt.org , FYRT created a message board to send out informational alerts on a wide variety of subjects and using formats like monthly "Questions to ponder". Examples of addressed subjects are: Stigma attached to employees with Bi-Polar disorders seeking work and the potential need of more community support of the Child Welfare Systems.

- In addition, on June 23rd, 2010, the FYRT organized the 3rd Annual Youth Summit (led by and centering around youth) titled "Embracing Diversity" where 500 community leaders, faith-based and community organizations, youth, adults and family members came together to learn about the most innovative programs, performers and agencies throughout San Diego County.

C. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas;

As stated in the contracted Statements of Work, the following standards are required:

1. Sites shall be located within four blocks of a public transportation stop and shall meet all related state and local requirements.
2. Program hours of operation must be convenient to accommodate the special needs of the service's diverse population. In most cases, evening or weekend appointment hours for treatment services shall be available and scheduled as needed for a minimum of four hours per week.
3. The program site shall be welcoming to the various cultural populations in the community and to individuals with co-occurring disorders (COD) by providing materials, brochures, posters and other information regarding cultural competence and COD.
4. Contractor shall demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities.
5. Outpatient mental health services shall be provided in accordance with the County of San Diego's Cultural Competency Plan, Culturally Competent Clinical Practice Standards, and the MHSA Gap Analysis.
6. Cultural Competence: Contractor shall comply with AOAMHS cultural competence requirements as referenced in the Organizational Provider Operations Handbook, Adult/Older Adult, and shall demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services Cultural Competency Plan.
    a. Contractor shall provide a Human Resource Plan that includes how contractor will recruit, hire and retain bilingual and culturally diverse staff.
    b. Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County.
7. Mental health services are based on BPSR principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community

members. BPSR guiding principles specify that services shall be client-centered, culture-centered, and built upon client's strengths.

8. Contractor shall assure that all staff complete four hours of Cultural Competence training annually.

To date, SDCMHS has not conducted an assessment, nor any other plan to facilitate ways for culturally and linguistically diverse populations to obtain services.

> *2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and*

Whenever applicable, the Adult/Older Adult MHS System of Care requires its services providers to comply with the facility standards as requirements in Statements of Work. Contractors' facilities must meet all related state and local requirements including the requirements of the American with Disabilities Act (ADA) and California Title 24.

In addition, contractors shall comply with all applicable provisions of the Organizational Provider Operations Handbook, Adult/Older Adult Services. The specific requirement for facilities: *In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations.*

> *3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and/or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)*

Through MHSA, the county has funded programs that include co-location of services and/or partnerships with primary care services in non-threatening community settings in an effort to better connect with ethnic/racial groups who are often more comfortable dealing with their family doctor. These efforts include:

Rural Health Initiative – This is a project within the Prevention and Early Intervention component of MHSA that intends to develop extensive behavioral health prevention, education, and intervention services within the context of several rural family practice clinics. The integrated component includes expansion of formulary (to include psychotropic medications) with the expectation of treatment of stable Seriously Mentally Ill (SMI) within the primary care (PC) team. A behavioral health consultant has been added to the PC team to enhance the integrated process and provide physician & client support. Implemented 1/1/2010.

Integrated Health Care Project (IHC-1) – This is a joint County Medical Services (CMS)/Mental Health (MH) pilot under development in which a primary care (PC) clinic is paired with a mental health clinic offering services to indigent clients. Stable SMI Adult, Older Adult, and Transition Age Youth (TAY) clients are referred to a community PC clinic to establish local a Patient-Centered Medical Home (PCMH). The PC doctors monitor the psychotropic medications and mental health wellness of the client in addition to addressing the client's physical health needs. Another feature of this pilot is that MH will be providing an additional "payment" to the PC clinic for each appointment that involves mental health facets of care or monitoring, as well as paying for psychotropic medications. Clients in crisis or in need of more specialized MH services will be referred back to the partner MH clinic. Clinic and treatment payments by County Medical Services ASO are paid from a separate MHSA account.

Physical Health Integration Project (INN-03) – This MHSA funded project will be funded under the Innovations component. It twins a primary care clinic and mental health clinic to provide a full continuum of care. Key facets of the project include:

- Imbedded Behavioral Health Consultant as part of the primary care team
- RN care coordinator as part of the MH clinic site to identify and refer MH clients in need of primary care treatment
- Alcohol and Drug counselor that works across sites to address co-occurring issues
- Specialized training of entire primary care team with regard to serious mental illness and destigmatization
- Transition of stable SMI clients from MH clinic to PC clinic
- Expansion of PC formulary to include psychotropic medications

The project is currently in the RFP process.

East County Integrated Health Access Project – This is a joint CMS/Mental Health pilot aimed at improving access to CMS-funded primary care for current MH clients. The East County Mental Health Clinic (ECMHC) is identifying indigent clients that are presenting with various physical health issues (such as diabetes, hypertension, high cholesterol, and other health risks) who are not eligible for Medi-Cal. Clients will work with the onsite HHS staff person who will assess their eligibility for CMS. The HHS staff person is able to enter client information directly into the CMS authorizing system, eliminating the need for an additional appointment (and subsequently reducing the processing time) at a Family Resource Center for CMS enrollment. Clients are given a one-page listing of local PC clinics while at the MH clinic, as well as the more comprehensive CMS services guide once they are deemed eligible for CMS coverage and linked with services. Initial coverage is for six months, which can then be extended for 12-18 months via recertification to be done through the same HHS staff person. The project was implemented October 1, 2009.

ADAPTATION OF SERVICES

III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

As discussed in Section II.D., above, for adult services, provider contract language contains the Standard Service Delivery Requirements which include:

"5. Contractor shall demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities."

The Organizational Provider Operations Handbook Cultural Competence Chapter (The Handbook is an addendum to the contract), in its Culturally Competent Clinical Practice Standards includes the requirements that:

"Staffing at all levels -- clinical, clerical, and administrative -- shall be representative of the community served."

"Services should be provided in the client's preferred language. Providers are required to inform individuals with Limited English Proficiency in a language they can understand that they have a right to free language assistance services." (For a complete listing of the Standards, please see the Appendix, Criterion 1, pp. 1.I.A.3-9.)

Diversity is sought in Source Selection Committee's (SSC), input and feedback is sought in Industry Days for draft SOW's, stakeholder and community forums, client and family focus groups provide input and feedback.

The Adult/Older Adult System of Care expects proposers to demonstrate 'a high level of achievement as an agency in providing culturally competent and culturally relevant services' through the submittal requirement in the Requests for Proposals (RFP) process. Proposers are also required to describe how the work specified in the Statement of Work, including meeting cultural competence requirements, will be accomplished.

ADAPTATION OF SERVICES

IV. Quality assurance

Requirements: *A description of current planned processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of services to consumers from diverse cultures including, but not limited to, the following:*

The county shall include the following in the CCPR:

A. List if applicable, any outcome measures, identification, and description of any culturally relevant consumer outcome measures used by the county.

The SDCMHS administered the Recovery Self-Assessment tool for the first time to adult clients in 2009 and then again in May, 2010. The tool includes a number of items which allow the client to rate his/her provider on their cultural competence, such as:

- . This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.
- This agency provides a variety of treatment options (i.e. individual, group, peer support, holistic healing, and alternative treatments, medical) from which agency participants may choose.
- Staff at this agency listen to and follow the choices and preferences of participants.

The SDCMHS's contracted UCSD Research Center is in the process of formulating a comprehensive report on the use of this tool and the results, expected to be available in November.

B. Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services; and

The SDCMHS administered the Recovery Self-Assessment (RSA) Tool to a sampling of clinicians to use as a measure of how culturally competent they thought that their programs were.

The full results of the RSA sampling are posted in Appendix, Criterion 3, pp. 3.V.B.1-14.

Among the clinicians sampled, most agreed or strongly agreed with the selected questions. It is interesting to note, however, that only about half or less of the clinicians felt that:

- Most services are provided in a person's natural environment (home, community, workplace.)
- People in recovery work along side agency staff on the development and provision of new programs and services.
- This agency provides a variety of treatment options.
- Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.

C. Grievance and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

Policy and procedures are in place through Policy #01-06-207 -- Grievances, Appeals, Expedited Appeals and State Fair Hearing: Monitoring the Beneficiary and Client Problem Resolution Process (see copy in Appendix, Criterion 8, pp. 8.IV.C.1-4) to monitor the beneficiary and client (both the general beneficiary population and ethnic beneficiaries) problem resolution process, ensure that client rights are maintained to their fullest extent, and ensure compliance with federal, state, and contract regulations.

San Diego County Mental Health Services Quality Improvement (QI) Unit is responsible for monitoring grievances, appeals, expedited appeals, and State Fair Hearings emanating from usage of the Beneficiary and Client Problem Resolution Process in order to identify trends and issues and make recommendations for needed system improvements. The QI Unit submits any required reports on grievances, appeals, expedited appeals and State Fair Hearings to the State Department of Mental Health as required.

In FY2008-09, there were two State Hearings, 65 Grievance Hearings and four Appeal Hearings which were all conducted in English. All hearings were service related and no grievances or appeals were filed regarding cultural competence or language barriers.